Orange County Fire Rescue

Public Record Requests

Post Office Box 5879
Winter Park, Florida 32793-5879
Phone: 407.836.9050 / Fax: 407.836.1919
FireRecords@ocfl.net

To Whom It May Concern:

Thank you for contacting Orange County Fire Rescue regarding your request for EMS Patient Care Reports. Due to the federally directed Health Insurance Portability and Accountability Act of 1996 (HIPAA), requests for records containing protected health information (PHI) must follow a strict process to ensure that the individual requesting the health information is authorized to receive it.

Attached, you will find an Authorization for Release of Confidential or Protected Health Information form. Please fill this out as completely as possible. Note the following requirements to ensure your completed form meets satisfactory compliance in order for records to be provided in a timely manner:

- The individual filling out the form **MUST BE** the patient, or the individual with legal authorization to grant the release of the patient's protected health information (e.g. parent of a minor or legal representative of the estate of a decedent).
- In the numbered section (1-3), please enter by which method you are requesting receipt of these records (e.g. enter the email, fax number, street address with contact name or self, attorney's office, insurance company, etc.).
- **THIS FORM MUST BE NOTARIZED TO BE VALID.** The patient/representative must sign and print his/her name in the bottom section, enter date of birth and date of authorization in the presence of a notary.

After proper execution of the form you may email, fax, or mail to Orange County Fire Rescue at the information contained in the header. You may also make an appointment to receive your records in-person at 6590 Amory Court, Winter Park, FL 32792.

Please note that our retention for emergency records is seven years, and non-emergency is two years. Records prior to 2010 may require more time to locate due to system changes. Not all reports outside our retention schedule may be available.

The fees for copies of records per Orange County Administrative Regulations are $0.15 per page, $0.20 per double-sided copy, or $1.00 per certified copy. An additional charge may be assessed to the actual costs of materials and supplies when the nature or volume of the records requested requires extensive* use of information technology resources, extensive clerical or supervisory assistance by County personnel. Records retrieval is estimated at five minutes per report from 2010 to the present, and approximately fifteen minutes per report prior to 2010 (if those records still exist). You will be billed at approximately $17.29/hour for these reports.

* For the purpose of this Regulation, "extensive" shall mean that it will require more than 15 minutes to locate, review the records for confidential or exempt information, copy and re-file the requested material.

If you have any questions, concerns or would like additional clarification, please feel free to contact us at any time.

Best Regards,

Public Records Custodian
Orange County Fire Rescue

For any non-medical public records, you may submit your requests by e-mailing PublicRecordRequest@ocfl.net – the information will be automatically processed and you will receive an automated response providing a request number and an electronic confirmation.

All medical billing and itemized medical requests must be obtained by contacting our third-party EMS billing services at 1-888-987-0840.

Our Public Records offices are open Monday-Friday, 9:00 AM to 5:00 PM. Please allow 3-5 business days for a standard request.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL OR PROTECTED HEALTH INFORMATION
Orange County, Florida

I, ____________________________ hereby authorize ______Orange County Fire Rescue______, its employees or agents, to release copies of my Confidential or Protected Health Information, ("PHI"), to the following individual(s), healthcare provider(s), entity(ies) or agency(ies).

Name(s) and address of individual, healthcare provider(s) entity(ies), or agency(ies) to receive the Confidential or PHI:

1. ____
(Please enter the email, fax or address you wish records to be sent to here)
2. ____
(Please enter the email, fax or address you wish records to be sent to here)
3. ____
(Please enter the email, fax or address you wish records to be sent to here)

For the purpose of:

Personal/Medical

(A statement "at the request of the individual" is sufficient if the client signs this Authorization and does not wish to give a specific reason.)

MEDICAL (INITIAL EACH BOX THAT APPLIES)

Information to be released may include:

- ☐ AIDS Information
- ☐ Drug and/or Alcohol Abuse
- ☐ Genetic counseling/testing
- ☐ Mental Health
- ☐ HIV Testing

The specific information to be disclosed shall include:

- ☑ Complete Record
- ☐ Abstract
- ☐ Clinical Resume
- ☐ Consultation Reports
- ☐ Procedures/Operative/Anesthesia
- ☐ Lab/X-ray/Diagnostic results
- ☐ Therapy record
- Specify Type ________________________________
- ☐ History & Physical
- ☐ Prenatal
- ☐ Progress notes
- ☐ Emergency/Urgent care
- ☐ Other (specify) ____________________ ____________________

Date(s) of service: ________________________________

CASE MANAGEMENT (INITIAL EACH BOX THAT APPLIES)

- ☐ Financial
- ☐ Social History
- ☐ Educational / School
- ☐ Other(specify)______________
- ☐ Other(specify)______________

I understand that I may select which information may be released by placing my initials in the area provided. PHI is confidential and protected by federal regulations, which prohibit further disclosure without specific written authorization from me or as otherwise permitted by federal and state law.

I understand that this Authorization may be revoked upon written notice to the following address ______6590 Amory Court, Winter Park, FL 32792______ except to the extent that action has already been taken in reliance on this Authorization. This Authorization may be revoked by writing or faxing and specifying the date this Authorization was signed. This Authorization will expire one year from today's date unless an expiration date or event is indicated.

I understand that this authorization is voluntary and that I may refuse to sign it. I further understand that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

Expiration date/event: ________________________________

______________________________ ______________ ____________________
Client/Parent/Legal Representative (Signature / Print) Client's DOB Date of authorization

____
Translator/Interpreter, if any (Signature / Print / Phone Number)

Type of Identification Presented

Witness________________________________ ____________________
(Signature / Print) Date

Revised: 6/18/14