

Candia, NH 03034

CANDIA FIRE DEPARTMENT

11 Deerfield Road Candia, NH 03034 Phone 603.483.2202 – Fax 603.483.2311



Report Request Form

I am requesting the Candia Fire Department record(s) types as indicated below:

INCIDENT REPORT. Report created by the Officer in Charge that complies with the rules of the National Fire Incident Reporting System (NFIRS).

FIRE INVESTIGATION REPORT. Not all fires will have a Fire Investigation Report. Depending on the incident complexity and other factors a report may not be completed for weeks or months. **PATIENT CARE REPORT.** A patient authorization form is required if the report contains confidential medical information and is requested by any party other than the patient or a court-ordered subpoena for records. A copy of the requestor/patient's photo ID must accompany these forms.

The information requested below must be completed in full. Requests without the required information will be returned to the sender. If you do not have the necessary incident information, you may contact the Candia Fire Department at 603-483-2202 or by email at mkelley@townofcandia.org.

Please note: All incident report requests are processed within fourteen (14) days of receipt. The department may require additional time to process requests and if so, an estimated time frame will be provided to the requestor.

Please	PRINT clearly: Requestor Name:				_
	Street:				
	City:				
	Telephone:	_ Email:			_
	Incident Date:	Inc	cident Time	(approx.):	_
	Incident Address:				_
	Type of Incident:				-
	Comments:				
Reques	stor Signature:			Date:	
Please	return this form to mkelley@townof	candia.org or by	y mail to:		
Attn: R	Fire Department ecords Request n Street				

Patient Care Reports: Must include a copy of the requestor/patient's identification <u>AND</u> a completed Authorization for Release of Protected Health Information.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPAA) [45 c.f.r. § 164.500 *et seq*. (2003)] and the New Hampshire RSA Chapter 332-I. Please review and complete the authorization carefully. Failure to provide all the requested information may invalidate the authorization. If you have questions about this authorization, please contact the Custodian of Records at 603.483.2202

PATIENT INFORMATION							
Patient Name (first middle last):	:		Patient DOB:				
Patient Address:							
Incident Date:	Incident Time:	ne: Incident # (if known):					
Incident Location:							
REQUESTING PARTIES INFORM	MATION						
Name of Requestor:		Pł	hone:				
Company/Organization:		Email:					
Address:							
Relationship to Patient: Self Parent of Minor or Disabled Adult Power of Representin	g Law	Beneficiary Subpoena	Patient Authorized Rep Spouse or	Executor of Estate Other:			
Attornov Attornov	Enforcement		Significant Other				
medical report. If the patient FORMAT OF RECORD RELEASE	is deceased, a copy of	the death certif		-			
You MUST provide a copy of the medical report. If the patient FORMAT OF RECORD RELEASE I request the record to be releat In Person Cert	is deceased, a copy of	the death certif anner:		ded with your request.			
You MUST provide a copy of th medical report. If the patient FORMAT OF RECORD RELEASE I request the record to be relea	is deceased, a copy of sed in the following m	the death certif anner:	icate must be incluc	ded with your request.			
You MUST provide a copy of the medical report. If the patient FORMAT OF RECORD RELEASE I request the record to be releat In Person Cert	is deceased, a copy of sed in the following m tified Mail mation to disclose: ily authorize the Candia Fire D esentative note above, I unde ediately after the disclosure. I a acilities receiving it, and may no te to hold harmless the Candia I of my medical records from the smission. I further understand nformation transmitted via em	the death certif	this medical record. As the so only pertains to the disc formation used or disclose by state or federal confider damages regarding the diss ant in electronic form via er ndia Fire Department, its e of electronic disclosure three	e patient, if I am authorizing the closure of the records described ad may be subject to re-disclosure ntiality laws. If you are the parent closure. I hereby understand and mail may not remain confidential imployees and/or agents, are not ough an unsecured email system.			
You MUST provide a copy of the medical report. If the patient FORMAT OF RECORD RELEASE I request the record to be releat In Person Cerr Email Address: Email	is deceased, a copy of ased in the following m tified Mail mation to disclose:	the death certif	this medical record. As the se only pertains to the disa formation used or disclose by state or federal confider damages regarding the disent in electronic form via er ndia Fire Department, its e of electronic disclosure thrc t be made in writing and wi	the patient, if I am authorizing the closure of the records described id may be subject to re-disclosure tiality laws. If you are the parent closure. I hereby understand and mail may not remain confidential imployees and/or agents, are not ough an unsecured email system. ill not affect information that has			
You MUST provide a copy of the medical report. If the patient FORMAT OF RECORD RELEASE I request the record to be releat In Person Cerr Email Address: Email	is deceased, a copy of ased in the following m tified Mail mation to disclose:	the death certif	this medical record. As the se only pertains to the disa formation used or disclose by state or federal confider damages regarding the disent in electronic form via er ndia Fire Department, its e of electronic disclosure thrc t be made in writing and wi	the patient, if I am authorizing the closure of the records described id may be subject to re-disclosure tiality laws. If you are the parent closure. I hereby understand and mail may not remain confidential imployees and/or agents, are not ough an unsecured email system. ill not affect information that has			

Please submit the following with your request:

- A clear copy of your driver's license or State-issued identification card. (Exceptions are made for Representing Attorneys and Law Enforcement).
- Documentation of legal representation/responsibility if you are not the patient.