Garland Fire Department
Request for Access to Health Information

Patient Name: _____ Phone: _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Date of Birth: _____ Patient Driver's License #_____

Date of Incident: _____ Approximate Time of Incident: _____

Address of Incident: _____

EMS Incident Number: (only if known): _____

Choose one Method on How You Would like Garland Fire Department to Provide Access

____ Mail to the following address: _____

____ Email to the following email address: _____

____ Fax to the following number: _____

____ Send a copy of the information to the following party:

Designated Party: _____

Street: _____

City: _____State: ____ Zip Code: _____

____ I will pick up and/or inspect a copy of the information in person at Garland Fire Department at 1500 Highway 66, Garland, TX 75040

***Signature of Requestor:* _____*Request Date:* _____**

Requestor Information (if requestor is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Please allow 15 business days for delivery

Faxed or emailed requests must include a readable clear copy of your driver's license, government issued photo I.D., subpoena, or signed HIPAA release document for medical records. I understand this is Protected Health Information. I am the patient, parent or guardian, and have written authorization, written permission, or Power of Attorney to receive medical records.

_____

Signature of Requester