



Burlington Fire Department

136 South Winooski Avenue
Burlington, Vermont 05401-8378

(802) 864-4554 • (802) 658-2700 (TTY)

Business Fax (802) 864-5945 • Central Station Fax (802) 865-5387



Requests for Access to PHI

1. BFD will require that all requests for access to PHI by a patient/personal representative be made in writing. BFD has created a form request letter, which it will make available to a patient/personal representative seeking access to PHI. *A copy of the form is attached to this Policy and Procedure.* In addition:

A. BFD will require appropriate verification of the identity of the patient/personal representative before providing any response to an access request. In this regard, BFD will follow the rules set forth in Paragraphs B and C below.

B. BFD will request that the verification process be completed in-person, at the BFD station at 136 South Winooski Avenue in Burlington. BFD requires a completed access form and a photo identification to complete the verification process, when the patient/personal representative appears in-person. BFD is not required to make the requested records available while the individual is present, but may do so if feasible, after the verification process has been completed.

C. BFD will permit the verification process to be completed via mail if the patient/personal representative presents a compelling reason for being unable to be present at the BFD station identified above. BFD acknowledges that compelling reasons could include residence out of state (with no in-state presence) and physical conditions that confine a patient/personal representative to the home. However, and for the sake of clarity, BFD will require the patient/personal representative to be present for the verification process where it is reasonably feasible for that person to travel to the BFD station. In those situations where BFD permits the verification process to occur via mail, BFD will require that the patient/personal representative send a completed request form, photocopies of a photo identification and social security card or birth certificate, and answers to several questions regarding the services provided by BFD (these questions are identified on the request form, and are designed to afford some reasonable assurance that the person requesting the information is, in fact, the patient/personal representative).



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Comments on Completion of Authorization Form

1. We have completed as much of the form as we can. However, there are a few sections for you to address. We are very well aware that you have the ability to successfully complete an authorization without coaching from us. However, our review time will be significantly reduced if you can follow these brief instructions.

Introduction. Please identify the name and date of birth of the person whose EMS incident report(s) you seek.

2. **Section 2.** Please indicate the specific lawyer, and law firm, to whom we are authorized to send the incident report(s).
3. **Section 3.** Please indicate the name of the person whom BFD served (of course, this should be the same as the name identified at the top of the form). In addition, please identify the specific service date or dates at issue.
4. **Section 4.** Please indicate the specific purpose of the disclosure of the EMS incident report(s). For example, "personal injury litigation involving Mr. Smith".
5. **Section 5.** Please note that we have indicated that the form is only valid for thirty (30) days after the individual/personal representative signs and dates the form. We think this should be sufficient. In addition, we believe that a short period is more protective of individual privacy than a lengthy period.
6. **No Changes.** Please do not make any changes to the form document, other than to complete the information identified above. We will not respond to requests using an altered form.
7. **Personal Representatives.** We trust you appreciate that a "personal representative" is a person with the authority to make health care decisions for an individual. In other words, although an attorney could be a personal representative, the fact that a person is an attorney does not make the attorney a "personal representative".



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City of Burlington Fire Department Authorization Form

Name: _____ Date of Birth: _____

(Of Patient)

(Of Patient)

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

(1) Who within the Burlington Fire Department (“BFD”) will use or disclose the information? The person(s) or classes of persons within BFD authorized to use or disclose the information are described below.

_____ BFD HIPAA Privacy Officer or designee

(2) To whom may BFD disclose the information? The person(s) or classes of persons authorized to receive the information are described below.

(3) What information will be used or disclosed? The specific information that may be used or disclosed is described below.

EMS Incident Report for _____, for services delivered by BFD on _____
(Patient Name) (date of incident)

(4) What is the purpose of each use or disclosure? The purposes for which the information will be used or disclosed are described below.



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(5) **When will this authorization expire?** The date or event that will trigger the expiration of this authorization must be described below.

Thirty (30) days after you, or your personal representative, signs and dates this form

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use and/or disclosure of your protected health information as described above. You understand that the information identified above could be re-disclosed by the recipients and, if so, may not be subject to federal or state laws protecting its confidentiality.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your enrollment or eligibility for health care benefits will not be affected if you do not sign this form.

You have a right to see and copy the information described on this authorization form in accordance with our record access policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that we have already taken action based upon your authorization. To revoke this authorization, please write to the **HIPAA Privacy Officer for BFD**, at 136 S. Winooski Avenue, Burlington, Vermont, 05401.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Individual or Personal Representative

Print Name of Individual or Personal Representative

Date

Description of Personal Representative's Authority