TOWN OF HANOVER
FIRE DEPARTMENT

32 CENTER STREET, HANOVER, MASSACHUSETTS 02339
TEL. 781-826-3151 FAX 781-826-4013

JASON CAVALLARO, *CHIEF*

FRED FREEMAN, *DEPUTY CHIEF* **GINO DEACETIS, *DEPUTY CHIEF***

Request for Fire Reports/Records

Fire Department records may be requested Monday through Friday 8 a.m. – 3:30 p.m., excluding holidays. The form may be dropped off at the Hanover Fire Department, faxed to 781-826-4013 or emailed to: hfdadm@hanover-ma.gov PLEASE PROVIDE A CONTACT NUMBER in case of any questions we may have regarding the request.

Complex request(s) may be assessed a monetary value of $.05 per page.

After receiving the request, records should be made available within 10 business days and subject to the approval of the Chief or Deputy Chief of the Fire Department.

REQUESTER:

Name:_____ **Company:**_____

Address:_____

Phone:_____ **Email:**_____

REQUEST CONCERNING:

Name: _____ **DOB:**_____

Address: _____

Incident Address: _____

Type of Incident: _____ **Incident Date:** _____

To request medical information please be sure to include HIPAA Authorization Form(s).

Additional Comments: _____

_____

Signature:_____ Date Requested:_____

*****If you have any questions please contact us at 781-826-3151 ext. 3203*****

Authorization for the Release and/or Discussion of Protected Health Information

Patient Name:_____ SS#: _____Birth Date:_/____ /___

Authorization

1. I, _____, hereby authorize
(Name of Patient or Patient's Legally Authorized Representative)

2. Name of person or organization:_____

Street Address: _____

City, state, zip:_____ Telephone: (

3. A. To release and/or discuss the following information

Complete Record Outpatient Care Inpatient Care

X-Ray Results Laboratory Results Treatment Plan Update

Other

_____

If my record contains the following information, it is also released if *CHECKED* in boxes below:

0 Substance Abuse *O* Mental Health Treatment DHIV Testing or Treatment

4. To _____of {name, address and phone of organization]

This information release is at my request for the purpose of legal assistance.

5 Signature:

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This authorization expires _ 6 months _ one year from today's date, or upon the following specified event:

_____

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed _____ Relationship_____Date: ___ /___ /___

Massachusetts Department of Public Health
Authorization for Release of Information
Permission to Share Information

If you want the _____ to share information about you with another person or
(Fill in name of person or organization)
organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, ---------- give my permission for _____
(print your name) (Fill in name of person or organization)
to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information

Please describe the information you want the _____ to share about you.
(Fill in name of person or organization)
Please include any dates and details you want to share.

_____

_____

_____

_____

B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

___ I specifically give permission, as required by M.G.L. c. 111, § ?OF, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

___ I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

___ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION Ill - Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

_____

_____

_____

SECTION IV - Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

_____
Name

_____
Organization

_____
Address

_____

SECTION V - Who May Receive My Information
The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

_____
Name

_____
Organization

_____
Address

_____

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI - How Long This Permission Lasts
This permission to share my information is good until _____
Indicate date or event
If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to _____, and send it or bring it to the place where I am now giving
(Fill in name of person or organization)
this permission (or fill in specific location) If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.

- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.

- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V - Signature
Please sign and date this form, and print your name.

_____ _____
Your Signature Date

_____
Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____