



PORT OF SEATTLE FIRE DEPARTMENT EMS DISCLOSURE FORM

Instructions for obtaining records:

1. Please complete the attached form as thoroughly as possible, including how you would like the requested records sent to you.
2. Return form and a legible copy of Photo I.D. to the Port of Seattle Fire Department by any of the means listed below.

Mail: Port of Seattle Fire Dept.
Attn: Records Requests
2400 South 170th Street
SeaTac, WA 98158

Email: fire@portseattle.org

Fax: 206-431-4908

Upon receipt of the completed form, along with a copy of your identification, the request will be processed. The records will be sent out within three business days, unless the incident dates back more than three years. Older records may take up to an additional three days.

For further questions, contact the Port of Seattle Fire Department at 206-433-5327.

PORT OF SEATTLE FIRE DEPARTMENT EMS DISCLOSURE FORM

I, (name) _____,
also known as (alias) _____,
authorizes the Port of Seattle Fire Department (2400 South 170th Street, SeaTac,
Washington 98158) to release medical aid records according to the following:

TO RELEASE TO: Personal / Facility: _____
Street Address _____ city / zip _____,

THE FOLLOWING INFORMATION FROM (CHECK ONE):

- Myself: Name _____ Birth Date: _____
 Child: Name _____ Birth Date: _____

EMS MEDICAL INCIDENT REPORT FOR:

Date: _____ Time: _____ Location: _____
For the purpose of: _____

I understand that records are protected under confidentiality regulations, and any records that contain information regarding drug and/or alcohol abuse that are created by an alcohol abuse or drug abuse prevention program are protected under federal confidentiality laws (42 CFR Part 2) and state law. I understand that said records containing information about the diagnosis, treatment or referral of alcohol and drug abuse problems cannot be disclosed without my written consent, and that those receiving this information are prohibited from re-disclosing these records unless expressly by my written consent. I understand that my records that contain information regarding HIV and/or confirmed STD tests or treatment are protected by State confidentiality laws (RCW 70.24.105) I understand that any HIV and/or confirmed STD tests or treatment records cannot be disclosed without my written consent unless permitted by State law, and that those receiving this information are prohibited from re-disclosing these records without my further written consent.

This consent may be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

Signature

Date

Telephone

Witness

Translator

SEND RECORDS TO: _____

_____ This is a: Mail Email Fax