NORTHSTAR FIRE DEPARTMENT
THIS HAS BEEN APPROVED

BY: _____ DATE: _____

NORTHSTAR FIRE DEPARTMENT

AUTHORIZATION FOR USE & DISCLOSURE OF PATIENT CARE REPORT (PCR)

A. Patient Information (All fields in this section are REQUIRED unless noted otherwise):		
Name:		
Address:		
Email address:	Cell Phone:	Last four of SSN:
Incident Location:		Incident Date:

B. Person/Organization Authorized to Receive the PCR – If you are requesting someone other than yourself to receive your PCR, please list who you are authorizing by completing the section below.	
Name (Required):	
Relationship (Required):	
Address:	
Email address:	Cell Phone:

C. Patient Representative – If you are completing this authorization on behalf of a patient, please indicate your relationship:
☐ I am the legal guardian.
☐ I am acting pursuant to a durable power of attorney.
☐ I am the conservator of the person.
☐ I am the executor or administrator of the estate of the person whose records are sought.
☐ I am a beneficiary of the estate of the person whose records are sought.
☐ Other (please describe):
***Please provide a copy of any document(s) that you have which grant you authority to request the patient's PCR (e.g. birth certificate for minor child, Medical Power of Attorney or Advance Health Care Directive, court order, etc.)**

AUTHORIZATION FOR USE & DISCLOSURE OF PATIENT CARE REPORT (PCR)

D. Your name and signature (REQUIRED):

- By signing this document, I am authorizing NFD to use or disclose my Patient Care Report (PCR) which may contain personal and medical information collected in relation to the Emergency Medical Service(s) provided by NFD.
- On the basis of the foregoing, I execute the foregoing AUTHORIZATION FOR USE & DISCLOSURE OF PATIENT CARE REPORT.
- The foregoing is true and correct of my own personal knowledge. I declare under penalty of perjury that the foregoing is true and correct.

Executed at:

_____ _____

(City/State) (Date)

_____ _____

(Signature) (Printed Name)

E. Identity Verification (REQUIRED) – Please provide one of the following:

☐ Attached is a copy of my government-issued photo identification which shows my signature.

☐ No photo identification is attached but my signature has been notarized below.

NOTARIZATION REQUIRED COMPLYING WITH CALIFORNIA GOVERNMENT CODE SECTION 1031.1 STATE OF CALIFORNIA, COUNTY OF PLACER

On _____, before me, _____, Notary Public

Personally appeared _____

Who proved to me on basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity (ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf on which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

[Place Seal and/or Stamp above] **Signature of Notary Public**

AUTHORIZATION FOR USE & DISCLOSURE OF PATIENT CARE REPORT (PCR)

FOR OFFICE USE ONLY: DO NOT COMPLETE BELOW THIS LINE

Comments:

Fee computed by: _____ Amount Due: $_____

Received by: _____ Amount Received: $_____

☐ Cash ☐ Credit ☐ Check No. _____ Invoice No._____

APPLICATION APPROVED

DISTRICT REPRESENTATIVE: DATE: