



Big Bear Fire Department

41090 Big Bear Boulevard, P. O. Box 2830, Big Bear Lake, CA 92315
Office: 909.866.7566 Fax: 909.866.8288 Email: fire@bigbearfire.org

Insurer/Health Plan Request to Examine and/or Copy Medical Records

FOR USE BY INSURERS, HEALTH PLANS AND OTHER RECIPIENTS AUTHORIZED BY CAL. CIVIL CODE § 56.10(c)(2) ONLY

Record Subject
(Patient's Name) _____
Last Name First Name M.I. Birth Date or Age

Address: _____
Street City State Telephone Number

I, the undersigned, am a duly authorized representative of:

Insurer, Employer, Health Care Service Plan, Hospital Service Plan, Employee Benefit Plan, Governmental Authority, Contractor, or Other Person or Entity Responsible for Paying for Health Care Services Rendered To The Patient, each as defined by the California Confidentiality of Medical Information Act ("Authorized Entity")

and am requesting the following medical information for above-named patient:

I acknowledge and agree that: (1) I and the Authorized Entity are duly authorized to receive the requested medical information without first obtaining patient authorization pursuant to **California Civil Code Section 56.10(c)(2)**, part of the California Confidentiality of Medical Information Act; (2) Big Bear Fire Department may request additional documentation to verify that I and/or the Authorized Entity are authorized to receive the requested information prior to disclosure by the Big Bear Fire Department; (3) the requested information will be used for the sole and exclusive purpose of allowing responsibility for payment to be determined and payment to be made by the Authorized Entity; (4) except as authorized by California Civil Code Section 56.10(c) or other applicable law, no other information about the named patient will be released without the patient's prior written consent; (5) the release or transfer of information received pursuant to this request to any person or entity not authorized to receive such information is prohibited by law; and (6) the Authorized Entity will be charged a fee as follows:

Fees	
Medical Records	\$15
File Research (minimum 15 min. increments)	\$35/hr

**I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS
TRUE AND CORRECT.**

Name (please print) _____ Signature _____
Title _____
Company _____
Physical Address _____
Mailing Address _____
Phone _____ Date _____

For Office Use

Request Received By: _____ Date: _____
Authorizing Officer: _____
Processed By: _____
Mailed/Picked Up-Date: _____

Fee Paid: \$ _____ FR-028
Check No.: _____
Receipt No.: _____

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