Medical Record Restriction Request

Patient Name: (print) ____

Street/PO Box: ____

City/State/Zip:____

Information to Restrict:

Incident No.____

Please indicate your request for restrictions to the uses and disclosures of your protected health information.

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Please allow 30 days to process this request. Hillsboro Fire & Rescue is not required to agree to any restrictions requested by the patient; however, any restrictions agreed to are binding.

____________________________________	______________________________
Signature of Patient or Other Person Authorized to Sign for Patient	Date
____________________________________	______________________________
Relationship to Patient	Printed Name

FOR HILLSBORO FIRE DEPARTMENT USE ONLY		
PAID: $ ______________	CHECK: # __________	☐ APPROVED FOR RELEASE
☐ NO RECORD FOUND		
☐ RECORD ENCLOSED		______________________________
☐ RELEASED DATE/BY:___________________		SIGNATURE AND DATE

Fire Department

Mail 240 S First Avenue, Hillsboro, Oregon 97123 Phone 503.681.6166 Fax 503.681.6208

Web www.ci.hillsboro.or.us/Fire