CITY OF LONG BEACH
FIRE DEPARTMENT
1 WEST CHESTER STREET
LONG BEACH, NY 11561
(516) 431-1002

SCOTT KEMINS
COMMISSIONER

Public Records Request

If you are requesting records that involve a request for assistance from the Long Beach Fire Department, please complete the REQUEST FOR PUBLIC INFORMATION form and give as much detail as possible regarding the incident, the date, time, location and type of alarm(fire, rescue, auto accident, etc.).

If you desire a copy of the Pre Hospital Care Report (PCR), which is a medical record, the HIPPA Form **MUST** also be completed.

All requests must include:

- A completed and signed REQUEST FOR PUBLIC INFORMATION form.
- HIPAA release form (only for aided report/ PCR requests)
- Copy of current Driver's License (only for aided report/ PCR requests)
- A Self-addressed, stamped return envelope
- Check or Money Order for $10.00 payable to City of Long Beach

Send all of the above items to:

City of Long Beach
ATTN: CITY CLERK - FIRE RECORDS
1 W Chester St
Long Beach, NY 11561

FIRE DEPARTMENT
CITY OF LONG BEACH
1 W. CHESTER ST
LONG BEACH, NY 11561
516-431-2434 - FAX: 516-431-7354

REQUEST FOR PUBLIC INFORMATION

I HEREBY APPLY FOR A COPY OF THE FOLLOWING RECORD:

☐ AIDED REPORT ☐ FIRE REPORT

NAME OF INDIVIDUAL INVOLVED IN THE IN INCIDENT – IF APPLICABLE

ADDRESS OF INCIDENT

DATE OF INCIDENT

NAME OF INDIVIDUAL MAKING REQUEST – PLEASE PRINT DATE

REPRESENTING PHONE #

MAILING ADDRESS OF APPLICANT CITY STATE ZIP

Signature of Applicant – ***Signature must be notarized if request is for an Aided Report/PCR by mail***

SIGNATURE DATE

AFFIX NOTARY STAMP HERE ▽

THE FOLLOWING MUST ACCOMPANY THIS FORM:

- Check for $10.00 payable to the **City of Long Beach**
- HIPAA release form (only for aided report/ PCR requests)
- Stamped, self-addressed return envelope

For Department Use Only:

___ APPROVED

___ DENIED

___ THIS DEPARTMENT HAS NO RECORD OF THIS INCIDENT

SIGNATURE TITLE DATE

You have the right to appeal the denial of this application to the head of this agency, who must fully explain the reason for such denial in writing within seven days of receipt of an appeal.

I HEREBY APPEAL:

SIGNATURE DATE

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
City of Long Beach, Fire Department, 1 W Chester St, Long Beach, NY 11561

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **PCR** _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize **City of Long Beach - Fire Department** (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**