~~Attachment E~~ Request for Report/Documents

Form 1050

Date of request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative Requesting Report/Document(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Agency requesting information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(city)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (state)\_\_\_\_\_\_\_, (zip)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of request:

Fire Report Incident Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Incident Number:\_\_\_\_\_\_\_\_\_\_

Date of Incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMS Report Incident Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Incident Number:\_\_\_\_\_\_\_\_\_\_

Date of Incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HIPAA yes no

Vehicle Accident Incident Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Incident Number:\_\_\_\_\_\_\_\_\_\_

Date of Incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HIPAA yes no

Other Report/Document Incident/Document Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Incident Number:\_\_\_\_\_\_\_\_\_\_

Type of Incident/Document:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Incident/Document:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HIPAA yes no

Fee: Request for Documents, per Copy

10¢ per page. # pages: \_\_\_\_\_\_\_\_\_\_\_\_ X 10¢ = $ \_\_\_\_\_\_\_\_\_

Additional Cost. # pages: \_\_\_\_\_\_\_\_\_\_\_ X \_\_\_\_= $ \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mileage, (2015) 57.5¢ per mile. X # Miles: \_\_\_\_\_\_\_\_\_\_ = $ \_\_\_\_\_\_\_\_\_

**Total due:** $\_\_\_\_\_\_\_\_\_\_

*Beckwourth Fire District use only*

Fees Paid: Yes No N/A

Request; Approved, Denied, If denied, explain,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Sent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Means: In person, faxed, e mail Mail

FD representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_