City Clerk's Office
Catherine A. Raynor, MMC, City Clerk
2250 Las Vegas Boulevard, North ·Suite 800 · North Las Vegas, Nevada 89030
Telephone: (702) 633-1030 · Fax: (702) 649-3846 · TDD: 7-1-1 Relay Nevada
www.cityofnorthlasvegas.com

EMS INCIDENT / MEDICAL RECORDS REQUEST

Incident Reports are considered public record and are available upon request. Requests for information, records, searches, etc. should be filed by the requestor in writing

North Las Vegas Fire Department requires a notarized release signed by the patient, in order to release records to anyone other than the patient. If a notarized release is not obtainable, you may request the records by court-issued subpoena. For your convenience, an Authorization for Use and Disclosure of Protected Health Information, with a place designated for the notary, is available upon request. Requests for medical records WITHOUT a **notarized release** signed by the patient or a court-issued subpoena will be returned to the sender. Your request will only be processed when the notarized release signed by the patient or a court-issued subpoena is submitted with the request.

Submit your request by visiting **http://www.cityofnorthlasvegas.com/departments/city_clerk** or contact the City Clerk's Office at (702) 633-1030. A form can be sent via fax or e-mail as a convenience (whichever applicable). You may also visit our website (noted above) for additional information.

Submit your completed Records Request Form by one of the following methods:

- Fax the City Clerk's Office at 702-649-3846. (Attn: Records Official)
- E-mail to **cityclerk@cityofnorthlasvegas.com**
- Mail the form to the City Clerk's Office (Attn: Records Official) at 2250 Las Vegas Boulevard North, Suite 800, North Las Vegas, Nevada 89030

Helpful Hints

- Please allow five (5) business days for a response.
- Duplicate submissions will not expedite your request.
- You will be notified of the appropriate amount due.
- Documents will not be released until payment has been received.

City of North Las Vegas incident medical records are not filed by name or social security number. To assist us in locating your request, we will need the **patient's name**, the **date**, **approximate time**, and **location** of the incident.

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How to Request an EMS Incident Report/Medical Records

- Reports involving any type of medical treatment are considered confidential information and may only be released to the patient or an authorized representative or agent of the patient.
- The patient may pick up a copy of their records in person by presenting current government issued ID, paying the appropriate fee(s) and signing upon receipt of the report.
- If the patient wishes someone else to pick up the report, they must present the items mentioned above, as well as a notarized release/power of attorney signed by the patient.
- Please note that all requests from attorneys or insurance companies for medical records must be accompanied by a notarized release from the patient.
- If a notarized release is not available, records may be requested by court-issued subpoena.
- Duplicate submissions will not expedite your request.
- EMS incident report and/or medical records are available for retrieval at the Fire Administration Building, by appointment only, with the Custodian of Records during the following business hours: Monday through Thursday from 7:00AM to 5:00PM (excluding Holidays).

Regardless of how you request a report/record(s), be prepared to provide the following information:

- **Patient Name**
- **Date and approximate time of incident**
- **Address or location where incident occurred**
- **Your name, phone number and how you are related to the incident**

Helpful Hints

- Whether you are the patient or the patient's representative, if you are going to retrieve the report/records in person, please contact the Custodian of Records to schedule an appointment upon receipt of an invoice.
- Please allow up to five (5) business days for a response.
- Submitting requests with complete information and/or required document(s) will allow for prompt processing.
- Please Note: City of North Las Vegas does not maintain any EMS records more than six (6) calendar years from the date of production.
- Any and/or all records that have reached the retention period have been destroyed in a secure manner.

Authorization For Use and Disclosure Of Protected Health Information (PHI)

(Notarized Release from Patient)

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security No.: _____

Date of Incident: _____ Approximate Time: _____

Location of Incident: _____

I hereby voluntarily authorize the City of North Las Vegas to disclose the PHI of the above named individual to the following persons or organizations (list name and address for each recipient):

_____

_____

_____

The undersigned hereby gives consent to the City of North Las Vegas to provide complete copies of medical records on the terms and conditions set forth pursuant to HIPAA. The type of information to be disclosed will include but not be limited to medical history, problems, allergies, medications, vital signs, nature of injuries and treatment.

I understand my released health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse; I acknowledge and hereby consent to such.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the information may be further disclosed and is no longer protected by federal privacy laws and regulations.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I have a right to receive a copy of this authorization. I may inspect or obtain a copy of my health information upon the proper notification to and under the conditions established by the Provider.

A photocopy of this authorization is as effective and valid as the original. The expiration date of this authorization is one (1) year from the date of the signature below. I understand that this authorization may be revoked by me at any time, except to the extent that action has already been taken in reliance upon it. I understand that to revoke this authorization, I must give written notice to the Provider.

Patient Signature: _____ Date: _____

If patient is unable to consent by reason of age or some other factor, state reason:

_____

_____.

_____ _____ _____

Signature of Legally Authorized Representative Date Relationship to Patient

STATE OF _____

COUNTY OF _____

SUBSCRIBED and sworn to before me this

_____day of_____, 20____

_____

Notary Public in and for said County and State