

# ORACLE FIRE DISTRICT~ RECORDS REQUEST FORM

Processing Time: Please Allow Approximately 10 Business Days

## Request in person or mail:

Oracle Fire District  
1475 W American Ave.  
PO Box 977  
Oracle, AZ 85623

## Request by fax or email:

Oracle Fire District  
Custodian of Records  
(520) 896-2749 – Fax  
tacosta@oraclefire.org

**Requestor Information:** Is this records request for a commercial purpose:  Yes  No (check one)

A.R.S. 39-121.03 D. For the purpose of this section, "commercial purpose" means the use of a public record for the purpose of sale or resale for the purpose of producing a document containing all or part of the copy, printout or photograph for sale or the obtaining of names and addresses from public records for the purpose of solicitation or the sale of names and addresses to another for the purpose of solicitation or for any purpose in which the purchaser can reasonably anticipate the receipt of monetary gain from the direct or indirect use of the public record. Commercial purpose does not mean the use of a public record as evidence or as research for evidence in an action in any judicial or quasi-judicial body.

Date of Request: \_\_\_\_\_ Reason for Request: \_\_\_\_\_

Requestor Name (Please print legibly) : \_\_\_\_\_

Requestor Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Requestor Signature: \_\_\_\_\_ Phone No: \_\_\_\_\_

Due to sensitive information, reports will NOT be sent via email.

### Fire Report:

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

Incident Address: \_\_\_\_\_

### Medical Report:

Information Requested:  Medical Report  Bill  Both

Patient's Name: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Incident Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Special Note for Medical Record Request** (ANY un-redacted record that contains a patient's protected health information): Patients requesting medical records must provide proof of identification (government issued photo I.D.). Third parties requesting a patient's medical record must attach one of the following to this Records Request Form: (1) a notarized HIPAA-compliant release, per 45 C.F.R. §164.508 signed by the patient; or (2) a court order signed by a judge authorizing release (45 C.F.R. §164.512). A subpoena without a HIPAA-compliant release or court order is not sufficient. For questions call (520) 825-5943 or email: sortiz@grfdaz.gov.

### Other:

Information Requested: \_\_\_\_\_

Please notify me to pick up this record in person  I am requesting this information be sent by mail