



Washington-Yuma Combined Communications Center

216 E 3rd, P.O. Box 96
Yuma, CO 80720
970-848-0464
www.wycomm.org

DISPATCH RECORDS REQUEST

Your Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Requesting Agency Name or Relationship: (victim, suspect, etc.) _____

Responding Agency Name: _____ Agency Case/Event Number: _____

Date of Incident: _____ Incident Address: _____

Person (s) Involved: _____

Type of record: *Incident event log (CAD card) _____ *List of calls _____ *Audio Recording _____

Purpose/Reason for requesting record:

Fees: Requests for records and/or audio recordings will be processed as follows: fees are \$41.37 per hour after the first hour including personnel and equipment, redaction, search and retrieval, pursuant to section 24-72-205 (6), C.R.S. All fees will be rounded to the nearest quarter hour. Requests will be fulfilled digitally and delivered via email unless otherwise requested, or if the data amount is too large for email delivery. If provided via hard copy or thumb drive form, the following fees apply in addition to any applicable recording fees: \$0.25 per page, or \$2.50 for a thumb drive. If mailed, applicable postage fees will be charged.

****Payment can be made by local, or cashier's check only. We do not accept cash or credit/debit cards. ****

Pursuant to C.R.S. 24-72-305.5: Records of official actions and criminal justice records and names, addresses, telephone numbers, and other information in such records shall not be used by any person for the purpose of soliciting business for pecuniary gain. The official custodian shall deny any person access to records of official actions and criminal justice records unless such person signs a statement which affirms that such records shall not be used for the direct solicitation of business for pecuniary gain.

By signing this form, I acknowledge and affirm that the records I obtain from Washington-Yuma Combined Communications Center as a result of this request shall not be used for the direct solicitation of business for pecuniary gain.

Requester signature: _____ Date: _____

* ID must be verified before records will be released. Please provide a copy of your government issued photo ID.

NOTICE: Records not picked up after 30 days from notification will need to be reordered. No refunds will be given, and new fees will apply.

OFFICIAL USE ONLY:

ID Verified: YES ___ NO ___ Amount Owed: _____

Payment Type: _____ (If by check, check number: _____)

Reason for Denial or Unprocessed: _____

Date/Time Contacted: _____ Msg: _____ Notes: _____

Records Released by : Email ___ Fax ___ USPS Mail ___ In Person ___

Processed by: _____ Date: _____

By signing below, you affirm the receipt and payment of any and all records as requested above.

Print Name: _____ Date: _____

Signature: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth
Patient Address	
Entity covered by release: Washington-Yuma Combined Communications Center and Select one: <input type="checkbox"/> Idalia Ambulance Service <input type="checkbox"/> South Y-W Ambulance Service <input type="checkbox"/> Washington County Ambulance Service <input type="checkbox"/> Wray Ambulance Service <input type="checkbox"/> Yuma Ambulance Service	
Name and address of person(s) or category of person to whom this information will be sent:	

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form. In accordance with 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 **protected health information** designated below. Please list the records you are authorizing for release with as much specificity as possible, including the type of record, date or date range, the specific subject matter, and the names of persons or locations. The authorization of the release of records relating to drug/alcohol abuse, child abuse, HIV status, genetic testing, sickle cell anemia, or mental health records must be specifically listed. A separate authorization is required for the release of psychotherapy notes.
2. 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.
3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law and Washington-Yuma Combined Communications is not responsible for any redisclosure.
4. This waiver is only valid for the specific records request made in conjunction with the release.

Select one:

- Idalia Ambulance South Y-W Ambulance
 Washington County Ambulance
 Wray Ambulance Yuma Ambulance

will request an individual waiver for each individual records request.

5. I understand I have a right to a copy of this authorization. I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect or amend my medical records as provided in 45 CFR 164.526. I have a right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.
6. Authorization to Transmit via Electronic Means: I acknowledge that if I request that the records listed above be released to the recipient by fax or email, and not by U.S. mail or delivery service, I understand the records will be sent through unencrypted fax/email that is not secure and there is a risk that the records could be seen by a third party during electronic transmission, while in electronic storage, and/or upon completed delivery. Morgan County is not responsible for unauthorized access of the Protected Health Information resulting from the faxed or emailed transmission, or for safeguarding the Protected Health Information upon delivery.

Specific information to be released:

- Medical Record from _____ to _____
(insert date) (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: _____

- Include: *(Indicate by Initialing)*

Alcohol/Drug Treatment

Mental Health Information

HIV-Related Information

Genetic Testing

Date: _____

Signature of Patient/Legal Representative

Print Name: _____

Relationship to Patient (if not patient): _____

If this form is not signed by the patient, provide documentation establishing authority such as Power of Attorney.