Morgan County Communications Center
Records Request Policy

The Morgan County Communications Center maintains call recordings of E-911 calls and other records as part of its day-to-day operations. These records may be subject to the Colorado Open Records Act ("CORA") or Colorado Criminal Justice Records Act ("CCJRA"), as applicable. These records are created as a result of the law enforcement and emergency medical services activities of the departments and other agencies that use the dispatch services of Communications Center.

Any records request for these records made to the Communications Center shall be made in writing on the form provided by the Communications Center. Anyone making a verbal request will be asked to submit the request in writing, and no action related to the request will be taken until a completed and a signed form is received. An individual wishing to obtain a copy of records that contain health information protected from disclosure under HIPAA must also complete and submit an Authorization to Release Medical Information.

All law enforcement agency records maintained by the Communication Center shall be initially classified as criminal justice records. The Communications Center shall provide the request form to the applicable law enforcement agency or agencies for review and a decision on whether the record or records, or any portion thereof, should be released to the requester. The Communications Center will provide the requester with the records as directed by the law enforcement agency or agencies or the law enforcement agency or agencies shall respond directly to the requester.

Morgan County Communications Center will only release records when any required payment is made to Morgan County, as applicable.

Records not classified as criminal justice records shall be routed to the appropriate County department or other agency for review and response.

Morgan County Open Records Request Form
Morgan County Communication Center Only

The following request is made under the Colorado Open Records Act or Criminal Justice Records Act:

Date: _____

Time: _____ a.m./p.m.

Name: _____

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

Phone Number: _____ Email: _____

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

Date of Incident: ___/___/_____
Incident Address: _____
Person (s) Involved:

_____

The cost for requested documents shall be $.25 per standard page or, for documents in non-standard formats, the actual duplication costs. Audio records shall cost _____. The hourly rate for any research or retrieval of records shall be charged at a rate of $33.58 per hour, after the first hour. In the custodian's sole discretion, the custodian may require a deposit of the estimated charges prior to the commencement of any research and retrieval of the requested records. All charges must be paid prior to any records are disclosed.

If the records requested contain protected health information, an authorization to release information and a copy of government issued identification of requester is included with this request.

_____ _____
Signature Date

For Official Use Only

Research time fee:
Time spent by staff - research and retrieval _____
Cost of research and assembly of request. $_____

Research Records requests received by:

_____ _____
Custodian Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth
Patient Address	
Entity covered by release: **Morgan County, Morgan County Ambulance Services**	
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 Morgan County is not responsible for any redisclosure.
4. This waiver is only valid for the specific records request made in conjunction with the release. Morgan County 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 form (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:_____

_____

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.