Santee Fire Department
Patient Care Report Request

Date of Incident: ____________________

Patient Name: ____

Requestor: ____

Relationship to Patient: ____

HIPAA Release Received: ☐ (If other than Patient)

Phone Number: ____

Reason for Request: ____

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Signature: ____ Date: ____________________

For Office Use Only:

Incident #: Fee Paid: Cash ☐ Check ☐ ID Verified ☐ Received By: