Records Request

Date of Request: _____

Incident Information

Date of Incident: _____

Type of Incident: ☐ Fire ☐ Medical ☐ Motor Vehicle Accident

☐ Other: _____

Requester Information

Full Name: _____

_____ _____ _____ _____

Address City State Zip Code

_____ _____

Phone Number Email Address

Comments:

_____ _____

Signature Date

*If you are requesting a medical record, you are required to submit the District HIPAA Release Authorization in conjunction with this request.

*Submit this request and all required documents to: administration@seweldfire.org

Southeast Weld Fire Protection District
95 W. Broadway Avenue – Keenesburg, Colorado 80643 – 303-732-4203
www.seweldfire.org