SAN FRANCISCO FIRE DEPARTMENT

Patient Request for Medical Record Form

Patient Name	
Date of Birth	
Date of Injury/Service	

I hereby request a copy of my medical record. I declare under penalty of perjury under the laws of the State of California that I am the patient who is the subject of the medical record being requested above.

Your Name	
Your Address* (Street, Apt#) (City, State, Zip	
Phone number	
Email Address	

All requests MUST include a PHOTOCOPY OF YOUR PICTURE ID, such as your state driver's license or passport.

Signature:_____ Date: _____

Please mail the **completed form** and **copy of picture ID** to:

SFFD – EMS DIVISION
Medical Records Unit
698 Second Street
San Francisco, CA 94107

*Your medical record CANNOT be mailed to a third party. The medical record will be sent to your home address as listed above. Phone and email are for contact purposes only. Incomplete requests shall be subject to denial.