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 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
1415 Evans Avenue
San Francisco, CA 94124

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