

CHANDLER POLICE DEPARTMENT

REQUEST FOR MEDICAL RECORDS – CRIME VICTIMS (OTHER THAN CHILD, VULNERABLE ADULT OR DOMESTIC VIOLENCE VICTIMS) (CFR § 164.512)

Patient: _____

Patient Date of Birth: _____ Patient SS# if known: ____ - ____ - ____

Name of Provider: _____

Date of Treatment: _____

Chandler Police Department, 250 E. Chicago Street, Chandler, AZ 85225, OR #: _____

The undersigned member of the Agency noted above, states that:

- I am a peace officer in the State of Arizona and am conducting an active investigation.
- The named patient is a suspected victim of the following crime: _____

- I need the information to determine whether a person other than the patient has violated the law.
- The patient's health information is not intended to be used against the patient.
- If I wait until the patient can agree to the release of his or her records, it would materially and adversely affect immediate law enforcement activity.
- I am seeking only the minimum amount of patient information the Agency needs for the investigation. The release of this information is authorized under HIPPA pursuant to CFR § 164.512.

Printed name of Officer / Detective

Title

Signed name of Officer / Detective

Date

For hospital personnel to document verification of officer's identity

_____ Badge number and Chandler Police Identification verified: Badge #: _____
