

Department Letterhead Here

Date: \_\_\_\_\_

St. Charles Medical Center  
Central Oregon Community Hospital

To whom it may concern:

We are investigating the following incident: \_\_\_\_\_

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For investigative purposes we are asking for information permitted to be disclosed as the person(s) is/are a (Please circle one):

Suspect    Fugitive    Material Witness    Missing Person    Victim

We are requesting the following information pursuant to HIPAA regulations CFR §164.512(f)(1)(i). Only one of the following need be provided for us to assist you.

(A) Name and address: \_\_\_\_\_

(B) Place of birth: \_\_\_\_\_

(C) Social Security Number: \_\_\_\_\_

(D) ABO Blood Type and RH Factor: \_\_\_\_\_

(E) Type of Injury: \_\_\_\_\_

(F) Date and Time of Treatment: \_\_\_\_\_

(G) Date and Time of Death, if applicable: \_\_\_\_\_

(H) A description of distinguishing physical characteristics:\* \_\_\_\_\_

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Thank you for your cooperation in this matter,

\_\_\_\_\_ Signature

\_\_\_\_\_ Printed Name

\_\_\_\_\_ Title

\*Physical characteristics permitted by law to be requested are height, weight, gender, race, hair, eye color, presence, or absence of facial hair (beard or moustache), scars, or tattoos.