AUTHORIZATION FOR RELEASE OF PENNSYLVANIA EMERGENCY MEDICAL SERVICES REPORT

The Pennsylvania Emergency Medical Services Report contains confidential information including medical histories, reports of actions and findings, summaries, diagnoses, records of treatment, medications ordered and administered, notes, entries and other written or graphical material maintained by the Philadelphia Fire Department pertaining to the individual receiving emergency medical care.
By my Signature below, I authorize the City of Philadelphia to release my Pennsylvania Emergency Medical Services Report(s) to:

1. INFORMATION RELEASED TO:
ADDRESS:

2. PATIENT'S NAME:	AGE	DATE OF BIRTH

ADDRESS

3. **REASON FOR RELEASE & DISCLOSURE**

Pennsylvania law restricts the purposes for which disclosures may be made. Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the redisclosure of such information.)

☐ At request of Patient [No description required]

☐ Other: Describe purpose _____

4. RELEASE:

The entire Pennsylvania Emergency Medical Services Report for the Incident described below.

Other (be specific): _____

HIV-RELATED INFORMATION AND/OR RECORDS WILL NOT BE INCLUDED WITH THE PENNSYLVANIA EMERGENCY MEDICAL SERVICES REPORT UNLESS THE PATIENT SPECIFICALLY REQUESTS IT TO BE. THE LINE BELOW MUST BE INITIALED BY THE PATIENT FOR THAT TYPE OF INFORMATION TO BE RELEASED:

I authorize the release of HIV/AIDS related health information and/or records. _____ (Patient's Initials)

PENNSYLVANIA EMERGENCY MEDICAL SERVICES INFORMATION

(Please supply as much information as is available, it will help the Department of Records to fulfill your request)

RECEIVING HOSPITAL	DATE OF SERVICE	TIME ☐ AM ☐ PM

LOCATION OF INCIDENT (EXACT STREET LOCATION WHERE INCIDENT OCCURRED)	PA EMERG MED SERV NO.

5. PATIENT'S SIGNATURE OR REASON IF THE PATIENT IS UNABLE TO SIGN:	DATE

FOR OFFICE: WHEN PRESENTED IN PERSON PROOF OF IDENTITY IS REQUIRED. TYPE: Approved by:	**IF PATIENT IS NOT PRESENT IN THE RECORDS DEPARTMENT OFFICE, ROOM 168 THE SIGNATURE MUST BE NOTARIZED.**

6. EXPIRATION: This authorization will expire once acted upon OR until:
Please indicate a date or event _____
An entry of **"NEVER"** will result in the rejection of this authorization.

7. a. You may revoke this authorization at any time except to the extent City Hall has taken action in reliance upon this authorization. See the City's Notice of Privacy Practices for more information about revoking an authorization.

b. You may refuse to sign this authorization. You do not need to sign this authorization to receive services from the City. If you refuse to sign this authorization, you will not be denied any treatment or benefits to which you were otherwise entitled.

c. Once your information is disclosed pursuant to this authorization, it may no longer be protected by Pennsylvania or Federal privacy law, and the person or organization that receives your information may have the legal right to disclose the information to other people or organizations without your knowledge or consent.

8. **RECORDS MAY NOT BE RELEASED WITHOUT SIGNATURE OF PATIENT**. If a patient is unable to sign (e.g., minor, deceased, physically or mentally incapacitated), a **legally qualified** representative (parent, next of kin, legal guardian, spouse administration, executor of estate) may sign in lieu of patient.

SIGNATURE OF LEGALLY QUALIFIED REPRESENTATIVE (READ STATEMENT ABOVE)	DATE

REPRESENTATIVE'S NAME (PRINT)	RELATIONSHIP TO PATIENT

If this authorization is signed by someone who is not the patient listed at the top of this form, provide proof and a description of the signer's legal authority to act for the patient to a Notary and return this form notarized.

IF PATIENT IS NOT PRESENT IN THE RECORDS DEPT. OFFICE, CITY HALL, ROOM #168, THE SIGNATURE MUST BE NOTARIZED.

NOTARY:

(The consumer will be provided with one copy of this form)