# RECORDS REQUEST: EMS

Release of all ambulance transport and care reports are regulated under HIPAA laws
and may only be released to authorized entities/persons

1. Complete Form: *Request for Records*
2. Complete Form: *Release of Medical Information Authorization*

3. (a) **PATIENT or AUTHORIZED ENTITY**, contact Division Chief of EMS by calling (317) 852-1190, ext. 3050

   (b) **ATTORNEY/INSURANCE COMPANY**, send completed information via secured fax direct to the Division Chief of EMS via (317) 456-0024

Brownsburg Fire Territory

*Vigilantly Serving Our Community*

# REQUEST FOR RECORDS

| *PATIENT'S FULL NAME: | |
|---|---|
| *DATE OF INCIDENT: | |
| *RANGE OF DATES BEING REQUESTED: | |
| *PICK-UP ADDRESS/LOCATION: | |

| *REQUESTOR'S FULL NAME: | |
|---|---|
| *RELATIONSHIP TO PATIENT: | |
| *EMAIL ADDRESS: | |
| *CONTACT PHONE NUMBER: | |

| *WHEN REPORT(S) IS/ARE READY (SELECT ONE): | ❑ I will pick-up<br>❑ Email<br>❑ Send secured fax to: ____________________________ |
|---|---|

*For Office Use Only:*

| INCIDENT #(S): | |
|---|---|
| RECORD RELEASE DATE: | |
| REP: | |
| INVOICE: | |

---

* *Information is required*

# Brownsburg Fire Territory

*Vigilantly Serving Our Community*

## RELEASE OF MEDICAL RECORDS AUTHORIZATION

PATIENT'S INFORMATION

Patient's Name (Last, First, MI)

Date of Birth | Social Security Number

Patient's Residence (Street, Apt#, City, State, ZIP Code)

PERSON REQUESTING RELEASE OF RECORDS (If different than patient) ________________________________

OBTAIN RECORDS FROM: *Brownsburg Fire Territory* ______________________________

PURPOSE OF THE DISCLOSURE: ________________________________________________________

Description of the Information to be released (kind and amount of information to be disclosed) (choose one):

- ❍ All information contained within the Medical Record Chart including information regarding the treatment of drug and alcohol, mental health and AIDS related records.
- ❍ All information, excluding drug and alcohol, mental health and HIV/AIDS related records
- ❍ Billing Statement
- ❍ Other specified records: ______________________________

I authorize the disclosure of information to be released as set forth herein.

I understand that I may revoke this authorization at any time in writing, unless the program or person which is to make the disclosure has already taken action in reliance on it. Otherwise, this authorization will terminate 60 days from the date signed.

______________________________ ______________________________
Patient's Signature | Date

I authorize the disclosure and/or release of my medical and billing information to the following people:

______________________________ ______________________________
Print Name | Relationship

______________________________ ______________________________
Print Name | Relationship

I understand that I may revoke this authorization at any time in writing, unless the program or person which is to make the disclosure has already taken action in reliance on it. Otherwise, this authorization will terminate 60 days from the date signed.

______________________________ ______________________________
Patient's Signature | Date

______________________________ ______________________________
Signature of person authorized to sign in lieu of the patient (where required) | Signature of Parent or Guardian (where required)

** Any records disclosed of the identity, diagnosis, prognosis or treatment of the patient which are maintained in performance of any drug abuse prevention function conducted, regulated or directly or indirectly assisted by any department or agency of the United States are protected by Federal confidentiality rules 42 CFR Part 2. The Federal rules prohibit you from making any further disclosure of this information, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigative or prosecute any alcohol or drug abuse patient.