

BERWYN FIRE COMPANY

Chester County Station 2 • 23 Bridge Avenue, Berwyn, PA 19312

Questions: EMSCaptain@berwynfireco.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Emergency Medical Services Records • Pursuant to HIPAA, 45 CFR § 164.508

ORIGINAL SIGNATURE REQUIRED

This authorization must bear the original, handwritten ("wet ink") signature of the patient or legal representative. Photocopies, faxed copies, scanned images, and electronic or digital signatures will NOT be accepted. Requests that do not meet this requirement will be returned unprocessed.

SECTION 1 PATIENT INFORMATION

PATIENT FULL LEGAL NAME (Last, First, Middle)	OTHER NAMES USED	DATE OF BIRTH
MAILING ADDRESS (Street, City, State, ZIP)	TELEPHONE	LAST 4 OF SSN (optional)
DATE(S) OF SERVICE / INCIDENT	INCIDENT LOCATION	INCIDENT / RUN NUMBER (if known)

SECTION 2 DISCLOSING ORGANIZATION

I authorize **Berwyn Fire Company, Emergency Medical Services, 23 Bridge Avenue, Berwyn, PA 19312** to release the health information described below.

SECTION 3 RELEASE INFORMATION TO

NAME OF PERSON OR ORGANIZATION	ATTENTION / CONTACT
ADDRESS (Street, City, State, ZIP)	TELEPHONE / FAX

SECTION 4 INFORMATION TO BE RELEASED

- | | |
|---|---|
| ☐ Patient Care Report (PCR / ePCR) | ☐ All EMS records for date(s) listed above |
| ☐ ECG / 12-lead / cardiac monitor data (if applicable) | ☐ Refusal of care / release documentation |
| ☐ Other: _____ | |

Specialty protected information. Pennsylvania and federal law require specific consent before the following may be released. Initial each item you authorize; any item left blank will be withheld:

_____ HIV/AIDS-related information	_____ Mental / behavioral health information
_____ Drug and/or alcohol treatment information	_____ Genetic testing information

SECTION 5 PURPOSE OF DISCLOSURE

- | | | |
|--|--|--|
| ☐ At patient's request (personal use) | ☐ Continuing medical care | ☐ Workers' compensation |
| ☐ Insurance / claims processing | ☐ Legal / attorney review | ☐ Other: _____ |

SECTION 6 EXPIRATION

This authorization expires on (date or event): _____. If no date or event is specified, this authorization will expire one (1) year from the date signed.

PATIENT NAME (continued from page 1)	DATE OF BIRTH
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SECTION 7 PATIENT RIGHTS AND ACKNOWLEDGEMENTS

I understand that:

1. I may revoke this authorization at any time by submitting a written notice to the Berwyn Fire Company Privacy Officer at the address above. Revocation will not apply to information already released in reliance on this authorization.
2. Berwyn Fire Company will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
3. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.

Questions about this form or your records may be directed to **EMSCaptain@berwynfireco.org**.

SECTION 8 SIGNATURE

Sign in ink. Photocopied, faxed, scanned, or electronic signatures will not be accepted.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE (original ink signature only)	DATE SIGNED
PRINTED NAME OF SIGNER	IF REPRESENTATIVE: RELATIONSHIP / AUTHORITY

If signed by a legal representative (e.g., parent of a minor, legal guardian, power of attorney, or executor/administrator of an estate), a copy of the document establishing that authority must be attached.

FOR BERWYN FIRE COMPANY USE ONLY			
DATE RECEIVED	RECEIVED BY	ORIGINAL SIGNATURE VERIFIED ☐ Yes ☐ No	PHOTO ID VERIFIED ☐ Yes ☐ N/A
DATE RELEASED	RELEASED BY	METHOD ☐ Mail ☐ In person ☐ Other	FEE COLLECTED