APPLICATION FOR EMS REPORT

PLEASE DO NOT SUBMIT AN APPLICATION WITH INSUFFICIENT OR INCORRECT INFORMATION; IT MAY RESULT IN "NO RECORDS FOUND"

CITY OF PHILADELPHIA
DEPARTMENT OF RECORDS

— PLEASE PRINT —

NAME OF APPLICANT REQUESTING REPORT	APPLICATION DATE

COMPLETE THIS BLOCK FOR EMS REPORT:

DATE OF SERVICE	TIME	NAME OF PATIENT

LOCATION OF INCIDENT *(EXACT STREET LOCATION WHERE INCIDENT OCCURRED)*

FEE FOR SEARCH AND / OR COPY ---$6.50 (NON-REFUNDABLE)
ALL INQUIRIES AFTER SUBMISSION, CALL EMS (215) 685-4205 AND REFER TO APPLICATION NUMBER ON FORM.

IF YOU HAVE A DISABILITY AND REQUIRE AN ACCOMMODATION IN ORDER TO COMPLETE THIS FORM CONTACT THE ADA COORDINATOR AT (215) 686-2266

REPORT TO BE MAILED TO:	TELEPHONE NUMBER OF APPLICANT

82-311 C Int. (Rev. 4/2021)

CITY OF PHILADELPHIA DEPARTMENT OF RECORDS

APPLICATION FOR EMS REPORT

REQUEST MUST HAVE DATE AND LOCATION OF EMS INCIDENT

REQUESTS FOR EMS REPORTS REQUIRE A COMPLETED AND SIGNED "AUTHORIZATION FOR RELEASE OF PA EMS REPORT" FORM; IT MUST BE NOTARIZED IF ORDERED VIA U.S. MAIL OR IF APPLIED FOR IN PERSON BY ANYONE OTHER THAN THE PATIENT

ADDITIONAL DOCUMENTS SUCH AS "POWER OF ATTORNEY", "LETTERS OF ADMINISTRATION", OR "DEATH CERTIFICATE" MAY BE REQUIRED IF APPLICABLE

AUTHORIZATION FORM IS AVAILABLE AT: WWW.PHILA.GOV/RECORDS GO TO POLICE/FIRE RECORDS UNIT CLICK EMERGENCY MEDICAL SERVICES (EMS) (form 82-311 C Int.)

SUBMIT APPLICATIONS TO:
DEPARTMENT OF RECORDS
ROOM 170, CITY HALL
PHILADELPHIA, PA 19107

FOR INQUIRIES AFTER SUBMISSION CALL PHILA EMS (215) 685-4205

TO EXPEDITE SERVICE, PLEASE SEND 2 SELF-ADDRESSED, STAMPED ENVELOPES.
MAKE BUSINESS CHECKS OR MONEY ORDER PAYABLE TO "CITY OF PHILADELPHIA".

$6.50 FEE IS NON-REFUNDABLE

PLEASE ALLOW 6-8 WEEKS TO RECEIVE COPY OR NOTICE OF "NO RECORDS FOUND".

AUTHORIZATION FOR RELEASE OF PHILADELPHIA FIRE DEPARTMENT ELECTRONIC PATIENT CARE REPORT

The Philadelphia Fire Department's Electronic Patient Care Report contains confidential information including medical histories, reports of actions and findings, summaries, diagnoses, records of treatments, medications administered, notes, and other type written or graphical material maintained by the Philadelphia Fire Department Division of Emergency Medical Services pertaining to the individual receiving emergency medical care.

By my signature below, I authorize the City of Philadelphia to release my electronic Patient Care Report(s) to:

****ONLY FORMS CONTAINING ORIGINAL SIGNATURES ACCEPTED FROM THIRD PARTY REQUESTORS - NO COPIES****

1. NAME AND ADDRESS OF WHOM TO RELEASE INFORMATION TO:

2. PATIENT'S FULL NAME:	AGE:	DATE OF BIRTH

PATIENT'S HOME ADDRESS:

3. **REASON FOR RELEASE & DISCLOSURE**

Pennsylvania law restricts the purpose for which disclosures may be made. Federal regulation requires a description of how much and what kind of information is to be disclosed. Federal law prohibits the redisclosure of such information.

☐ At the request of the Patient [No description required]

☐ Other: Describe purpose: _____

4. RELEASE:

☐ The entire Electronic Patient Care Report for the incident described below

☐ Other (be specific): _____

HIV-RELATED INFORMATION AND/OR RECORDS WILL NOT BE INCLUDED WITH THE ELECTRONIC PATIENT CARE REPORT UNLESS THE PATIENT SPECIFICALLY REQUESTED IT TO BE. THE LINE BELOW MUST BE INITIALED BY THE PATIENT FOR THAT INFORMATION TO BE RELEASED:

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

EMERGENCY MEDICAL SERVICES INCIDENT INFORMATION

(*Please supply as much information as is available, it will help to locate your requested report*)

LOCATION OF EMS ENCOUNTER (BE SPECIFIC):	DATE OF SERVICE	TIME ☐ A.M. ☐ P.M.

RECEIVING HOSPITAL	INCIDENT OR ACCOUNT NUMBER – IF KNOWN

PATIENT'S SIGNATURE OR REASON WHY THE PATIENT IS UNABLE TO SIGN	**ELECTRONICALLY CAPTURED OR CREATED SIGNATURES ARE NOT VALID. AUTHORIZATION WILL BE REJECTED**	DATE

FOR DEPT. OF RECORDS USE ONLY: WHEN PRESENTED IN PERSON PROOF OF IDENTITY IS REQUIRED

ID TYPE: APPROVED BY:

6. EXPIRATION: This authorization will expire once acted upon OR until: _____(date). An entry of "**NEVER**" will result in a rejection of this authorization.

7. a. You may revoke this authorization at any time except to the extent PFD-EMS has taken action in reliance upon this authorization. See the PFD-EMS'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 service from PFD-EMS. If you refuse to sign this authorization, you will not be denied any treatment or benefits to which you are otherwise entitled.

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

8. **RECORDS WILL NOT BE RELEASED WITHOUT A SIGNATURE OF PATIENT.** If patient is unable to sign (e.g., minor deceased, incapacitated, etc.) a **legally qualified** representative (parent, legal guardian, executor of estate, Medical Power of Attorney, etc.) may sign in lieu of patient. **ATTORNEYS DO NOT SIGN WITHOUT MEDICAL POA.**

If signed by a representative; supporting documentation is required with submission (Medical POA, Letters of Administration, proof of guardianship, etc.)

SIGNATURE OF LEGALLY QUALIFIED REPRESENTATIVE (*READ ABOVE STATEMENT)*	**ELECTRONICALLY CAPTURED OR CREATED SIGNATURES ARE NOT VALID. AUTHORIZATION WILL BE REJECTED**	DATE

REPRESENTATIVE'S NAME (PRINT)	RELATIONSHIP TO PATIENT

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

NOTARY:

STAMP/SEAL **SIGNATURE** **DATE**