

Pettis County Ambulance District

Emergency Medical Services (EMS) Report Request Information

Health Insurance Portability and Accountability Act (“HIPAA”): *Emergency Medical Service (EMS) Reports*
EMS reports are considered confidential medical records and are protected by privacy laws. Please use the **Authorization for Release of Protected Health Information** form to request the record. A clear legible copy of photo identification (driver’s license) must accompany and be attached to the request prior to release of the report.

Most third party requests require either a HIPAA authorization signed by the patient or a court order.

Pettis County Ambulance District may give a report for a deceased individual to the personal representative of the estate with a completed Authorization for Release of Protected Health Information a copy of the death certificate and court order showing the appointment of the personal representative.

A report may be released to the guardian of a minor (with proof of legal guardianship), a healthcare decision maker (or an individual authorized to make health care treatment decisions for the patient, including the parent of a minor or an agent pursuant to a healthcare power of attorney) with completed Authorization for Release of Protected Health Information.

Subpoenas from a Prosecuting or District Attorney's Office do not require a HIPAA authorization signed by the patient.

If you are requesting EMS records:

Complete and submit the Request Form for EMS Incident Report and Authorization for Release of Protected Health Information Form by email to recordsrequest@pcad653.com or mail to:

Pettis County Ambulance District
Attn: Medical Records
P.O. Box 1383
Sedalia, MO 65302

Pettis County Ambulance District
Request Form for EMS Medical Records

I am requesting a Pettis County Ambulance District record of an EMS/MEDICAL REPORT. A patient authorization form is required if the report contains protected health information ("PHI") or patient identifiable information ("PII") and is requested by any party other than the patient or a court ordered subpoena of records. Court Orders do not require additional information; however, patients MUST provide photo identification before the report can be released. A copy of their photo ID shall be attached to the completed EMS Incident Request Form.

All information requested below must be completed in full. Requests lacking this required information will be returned to sender. If the necessary information is unavailable, contact the Pettis County Ambulance District Administration office at (660) 829.0777 or by email at: recordsrequest@pcad653.com

Please note: All records requests are processed within seven (7) business days upon receipt. It is our policy to fulfill record requests within 10 business days of the incident date. The District may require additional time to process more difficult requests and if so, an estimated time frame will be provided to the requestor.

Please print clearly:

Requesting Party's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) ____ - _____

Email: _____

Incident Date (mm/dd/yyyy): _____

Incident Address: _____

Type of Incident:

Medical Traumatic injury Other (specify): _____

Additional Comments if necessary:

Requesting Party's Signature

Date mm/dd/yy

Please return this form, along with a valid HIPAA Authorization, supporting documentation signed by the patient, if applicable, to:

Pettis County Ambulance District Attn: Records
P.O. Box 1383
Sedalia, MO 65301
Or email to: recordsrequest@pcad653.com

PCAD Use Only
Incident #: _____
Date Rcv'd: _____
Initials: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPPA)

Please review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization. If you have questions about this authorization, please contact the EMS Chief or Assistant Chief at 660.829.0777

Patient Information

Patient Name (first / middle / last): _____

Incident Date mm/dd/yy: _____

Incident Number (if known): _____

Incident / Scene Location: _____

Requesting Party Information

Name of Requesting Party: _____

Phone #: __ (____) ____ - _____

Requests by Company / Organization

Company/Organization Name: _____

Email: _____

Address: _____

Relationship to Patient (check one):

- | | | |
|---|--|---|
| <input type="checkbox"/> Parent of Minor | <input type="checkbox"/> Patient Authorized Representative | <input type="checkbox"/> Representing Attorney |
| <input type="checkbox"/> Parent of Disabled Adult | <input type="checkbox"/> Executor of Estate | <input type="checkbox"/> Law Enforcement |
| <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Subpoena |
| <input type="checkbox"/> Beneficiary | | <input type="checkbox"/> Spouse / Significant other |

You MUST provide a copy of the legal authority you have to make medical decisions for the patient listed on the medical report. If the patient is deceased, a copy of the death certificate must be included with the request.

Format of Record Release

I request the record to be released in the following manner:

- In Person Mail Email Fax

Limitations (check one):

- No limitations on the type of information to disclose

 Limited to: _____

Patient Authorization of Records Release

By submitting this form, I hereby voluntarily authorize the Pettis County Ambulance District to release the specified medical record(s).

As the patient, I am authorizing the release of my medical record to the representative noted above. I understand that the release only pertains to the disclosure of the record described herein. This authorization shall expire immediately after the disclosure.

I also understand that information used or disclosed may be subject to re-disclosure by the person, agent, class of persons or facilities receiving it, and may no longer be protected by state and federal confidentiality laws. If you are the parent of a minor and represent as such, you agree to hold harmless the Pettis County Ambulance District from damages regarding the disclosure.

I hereby understand and agree that requests for electronic copies of my medical records from the Pettis County Ambulance District in electronic form via email may not remain confidential due to the unsecure nature of email transmission. I further understand and agree that the Pettis County Ambulance District, and its employees and/or agents, are not liable in any manner for the disclosure of information transmitted via email request, by virtue of electronic disclosure through an unsecured email system.

I understand that I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.

Patient Signature: _____

Date: _____

<OR>

Signature from Other/NOT Patient: _____

Date: _____

I have been advised of my right to receive this authorization and request a copy of it when records are released.

Substantiating Information:

Please submit the following with your request:

- A clear copy of your Driver's License or State-Issued Identification Card whether or not you are the patient. (Exceptions are made for Representing Attorney and Law Enforcement)
- Documentation of legal representation/responsibility if you are not the patient
- Submit this form to the address/email at the top of this page