Hackensack Volunteer Ambulance Corps, Inc.
PO Box 278, Hackensack NJ 07602

Hackensack Volunteer Ambulance Corps, Inc.

Request A Patient Care Report

Federal and state law strictly limits who may obtain your confidential patient care report.

You are requesting a patient care report from the Hackensack Volunteer Ambulance Corps, Inc. Although operating 24 hours a day, the Corps' primary service hours are 6PM-6AM. If an agency other than the Hackensack Volunteer Ambulance Corps provided care and/or transport for this patient, you will need to contact that agency for the patient care report. If care/transport was provided by a Hackensack University Medical Center Ambulance, please contact (551) 996-2000 for information on how to obtain a patient care report.

Patients

If you wish to request your patient care report, please download and print this form, complete and sign it, and mail it to: Hackensack Volunteer Ambulance Corps, Inc., Attn: The Secretary, PO Box 278, Hackensack NJ 07602. The form *must* be signed by the patient unless the patient is not capable of signing or has deceased. In the case of a patient not capable of signing on his/her own behalf, the form may be signed by a guardian or durable power of attorney. In the case of a patient deceased, the form may be signed by his/her spouse or other next of kin or his/her executor.

Attorneys

Private attorneys seeking patient care reports in conjunction with litigation must submit a request in writing, which must include the following information: incident date; incident location; approximate time of incident; and the patient's name. A signed Medical Release Form must be attached to the request letter.

Law Enforcement

Please contact us to discuss the circumstances under which we can release a patient care report to law enforcement.

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Patient Request for Copy of Patient Care Report

Patient Name:	
Date of Transport:	Today's Date:

Patient Contact Information

Address:
City State Zip:

This form should be returned to by mail:

Hackensack Volunteer Ambulance Corps, Inc.
Attn: The Secretary
PO Box 278
Hackensack NJ 07602

Please send the Patient Care Report to:

Name:
Address:
City State Zip:

Patient Rights:
You have the right to access, copy and/or inspect your protected healthcare information (PHI). You may also have the right to request that we amend your PHI, or request that we restrict access to, or the use and disclosure of, your PHI. These rights are further described in our Notice of Privacy Practices and in other policies, which we will send to you upon request.

Please send me a copy of my patient care report.

Patient signature:
Parent or Legal Guardian's signature (if patient under 18 years old):

Subscribed and sworn to before me in the county of _____, State of _____,
this _____ day of _____ , 20____.

Notary Seal

_____ _____
Notary's official signature *Commission Expiration*

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HIPAA COMPLIANT AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEAL TH INFORMATION

1.) To: Hackensack Volunteer Ambulance Corps, Inc., PO Box 278, Hackensack NJ 07602.

2.) Patient Name: _____ Date of Birth: _____

Patient Address: _____ Social Security No.: _____

3.) _X_ ALL DATES OF SERVICE

4.) Authorization to Disclose PHI Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"):

This is to authorize and instruct you to furnish to: _____ (**include full name and address of requester**) the following specific medical records constituting protected health information (or "PHI") as that term is defined by HIPAA, including any regulations enacted pursuant thereto, including opinions, reports, x-rays, scans, films, ultrasound records, bills, summaries, photo static copies, abstracts, or any other records, information or documents that you may have in your custody or under your control regarding the patient whose name appears above:

_X_ **All records, new patient reports/questionnaires, intra-operative photographs, original x-ray films, MRI films, CT scan films, bone scan films and/or any other type of films in your possession or control concerning treatment or care provided to the patient named above, whether made by you or others.**

If psychiatric records, HIV/AIDS information, substance abuse information, tuberculosis information, genetic information, hepatitis C and/or sexually transmitted disease information is included in these records, **initial** next to the appropriate line below in order to include such records in this release:

___HIV/AIDS Related Information
___Genetic Information
___Drug and Alcohol Information
___Hepatitis C Information
___Mental Health and Psychotherapy Information
___Sexually Transmitted Disease Information
___Tuberculosis Information

NOTE: If this section is left blank, authorization to release psychiatric records, HIV/AIDS records and substance abuse records will be presumed to be DENIED.

This release is given for the purpose of litigation. The privilege I have to maintain the confidentiality of this PHI is not waived for any other organizations, individual or insurance company not named herein. I acknowledge that this information may be further disclosed for purposes related to the case(s) I am involved in or the claim(s) I have brought or are advancing, and for the purposes of defending such case(s) and/or claim(s), or as otherwise permitted by law, and that the terms of this authorization may not be binding upon persons to whom such a further disclosure is made. By affixing my signature below, I acknowledge that I waive all liability whatsoever for any person who cooperates with this request to release medical records. A photocopy of this release may be used in place of the original. This release expires twelve (12) months from the date below. I understand that I may receive treatment from any healthcare provider mentioned in this release without executing this release. Further, I understand that this release may be revoked in writing by me. However any actions taken by any party in reliance upon this release, taken before the written revocation is received by that party won't be affected by the revocation.

Printed Name: _____ Patient ID#: _____
(Number Used by CE to Identify Patient)

Signature: _____ Dated: _____

If Patient's personal representative, describe relationship to patient: _____