CHEVRA HATZALAH
AMBULANCE CALL REPORT REQUEST FORM

Today's Date: _____

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Fax: _____

I, (patient's name): _____

Request (please check): Ambulance Call Report _____ Refused Medical Assistance Form _____

Date of Incident: _____

Time of Incident: _____

Location of Incident: _____

Medical Problem: _____

Name of Hospital: _____

Reason for Request: _____

Signature: _____

Please return request to:

Fax: 718-998-7834

Mail: Chevra Hatzalah
1070 McDonald Avenue
Brooklyn, NY 11230

Email: chany@hatzalah.org

Questions: 718-998-9000

Notary:

HIPAA AUTHORIZATION

Patient's Name: _____ DOB: _____

The records and information are being requested at the direction of the individual and are required in order to evaluate the nature and extent of injuries and/or illness claimed by the individual relating to an accident that occurred on or about _____, and to evaluate said individual's claim related to said accident.

Specific description of information to be disclosed: Entire medical chart including, but not limited to, emergency room records, hospital records and/or reports, doctors' office records and/or reports, x-ray films and/or reports, MRI films and/or reports, any other radiological films and/or reports, medical billing records, Social Security records, Workers' Compensation records, police reports and/or photographs, other investigative reports, insurance records, including no-fault records, school records and/or transcripts, employments records and/or lost wages records, and income tax records.

Dates of Treatment: _____
I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

Initials: _____

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials: _____

I understand that this authorization will expire One (1) Year from the date of the original signature indicated below. A photocopy of this Authorization has the same effect as the original.

Initials: _____

IF THE REQUESTED RECORD RELATES TO PSYCHIATRIC TREATMENT OR DRUG AND/OR ALCOHOL TREATMENT, OR CONTAINS HIV-RELATED INFORMATION, YOU MUST SPECIFICALLY INDICATE YOUR CONSENT TO THE RELEASE OF SUCH INFORMATION BY INITIALING THE FOLLOWING PARAGRAPHS.

Psychiatric Records: I understand that if my records pertain to psychiatric treatment, such information will be released pursuant to this authorization form.

_____ (Patient/Legal Guardian's Initials)

Notice: New York State law prohibits a recipient from re-disclosing mental health information without the subject's authorization unless permitted to do so under Federal or State Law.

Substance Abuse (Drug and Alcohol) Treatment Records: I understand that if my records pertain to participation in a substance abuse treatment program, as defined in 42 CFR Part 2 of the Federal Regulations, or contain information about my treatment at the Hospital for drug or alcohol abuse, such information will be released pursuant to this authorization form.

_____ (Patient/Legal Guardian's Initials)

Notice: Federal law requires that the recipients be provided with the following statement:
"This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

HIV-Related Information: I understand that if my records contain confidential HIV-related information, such information will be released pursuant to this authorization form. Confidential HIV-related information includes information indicating that a person had an HIV-related test, or has an HIV-related infection, or HIV-related illness, or AIDS, or any information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts.

_____ (Patient/Legal Guardian's Initials)

Signature: _____ Notary:

Print Name: _____

Date: _____