**Ocean City Fire Department/ Career Division**
**1409 Philadelphia Ave. / P O Box 158**
**Ocean City, MD 21843-0158**
**Phone: 410-520-5427 Fax: 410-289-6473**
ocfdreportrequest@oceancitymd.gov

To Whom It May Concern:

It is the policy of the Ocean City Fire Department – Career Fire/EMS Division not to release any patient information and/or medical records unless Care Report Release has been completed by the patient or legal representative. This policy ensures that the patient's rights and confidentiality are kept in accordance with current guidelines proposed by the health care industry. **Patient medical records during incident response, ambulance transport, and /or patient refusal only will be released. OCFD does not do billing, all request for billing information must go to Medical Claim Aid (separate form)**

**TOWN OF OCEAN CITY-OCEAN CITY FIRE DEPARTMENT**
**EMS PATIENT CARE REPORT RELEASE OF HEALTH INFORMATION FROM AMBULANCE TRANSPORT WAIVER**

Patient's Name: _____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Social Security No.:_____ Date of Service:_____

***Patient Rights:*** As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies which you may have upon request.

***Release to be made:*** To patient only over the age of 18. Patients under the age of 18 release must be completed by parent or legal guardian
To Law Firm or Legal Representation (with proper documentation)
To spouse, child (over age 18), or Legal representation of deceased patient

**To better allow us to process your request, please indicate the type of request you are making on this form (check all that apply)**

- ☐ Obtain a copy of my health information from Ambulance Transport &/or Refusal
- ☐ Potentially request amendment of my health information.
- ☐ Potentially request an accounting of how my PHI has been used and disclosed to others.
- ☐ Potentially request restrictions on the use and disclosure of my health information.

I authorize the Custodian of Records to release my health information records for the purpose(s) specified above.

Name of person making request: _____ Request date: _____

Signature: _____ Relationship to Patient: _____

Parent/ Legal Guardian Name: _____

***Return completed waiver via fax or to email above with copy of ID***

**I authorize the Custodian of Records to release and E-mail my records** (unless signed, records will be mailed or faxed)

Signature: _____ Email Address:_____

Please mail report to the following address (if different than the address shown above):

_____

**REQUEST MUST INCLUDE COPY OF ID** (ID information must match)

Upon receipt of the Release Waiver, we will forward a copy of the report as instructed. Should there be any questions and/or comments, please contact the Career Division Deputy Chief, at the address shown above.

Processed by:_____ (Custodian of Records) Date: _____