REQUEST FOR RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

- Patient Name.....
- Date of Service.....
- Location of Service.....
- Provider Name – Charlottesville – Albemarle Rescue Squad, Inc, and/or Charlottesville Fire Department, and/or Albemarle County Fire Rescue Department
- Person, agency or provider to whom disclosure is to be made, if not to patient:
  …..
- Address, or Email address:.....
- Information or Records to be disclosed – All, including Virginia Prehospital Patient Care Report

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. **The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.**

If the records are those of a deceased or mentally incapacitated patient:
FIRST: to the personal representative or executor of the deceased patient or the legal guardian or committee of the incompetent or incapacitated patient
SECOND: if there is no personal representative, executor, legal guardian or committee appointed, to the following persons **in the following order of priority**: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased patient in order of blood relationship

I certify that I am entitled to receive the above requested record because the patient is deceased or incapacitated and there is no other person of higher priority (as set forth in the above paragraph) that is entitled to receive the record.

Signature of Requesting Party: _____ Date: _____

Printed Name of Requesting Party:_____

(If not the patient, then relationship to patient: _____)

Mail to: PPCR Records Request, 828 McIntire Rd., Charlottesville, VA 22902

OR Fax to: 434-296-1146 OR Scan, or photograph, and Email to: records@rescue1.org