EMS Records Custodian
445 N. REXFORD DRIVE
BEVERLY HILLS, CA 90210
(310) 281-2700
Email: BHFDRecords@beverlyhills.org

(Official Use Only)

Received On: _____

Received By: _____

AUTHORIZATION FOR USE & DISCLOSURE OF PATIENT CARE REPORT (PCR)

A. Patient Information (All fields in this section are **REQUIRED** unless noted otherwise):

Name: _____

Date of Birth: _____ Last four of SSN: _____

Address: _____

Telephone: _____ Email (optional) : _____

Incident Date: _____

Incident Location: _____

B. Person/Organization Authorized to Receive the PCR – If you are requesting someone other than yourself to receive your PCR, please list who you are authorizing by completing the section below.

Name (Required): _____

Relationship (Required): _____

Address: _____

Telephone: _____ Email: _____

C. Patient Representative – If you are completing this authorization on behalf of a patient, please indicate your relationship:

___ I am the legal guardian.

___ I am acting pursuant to a durable power of attorney.

___ I am the conservator of the person.

___ I am the executor or administrator of the estate of the person whose records are sought.

___ I am a beneficiary of the estate of the person whose records are sought.

___ Other (please describe) _____

**Please provide a copy of any document(s) that you have which grant you authority to request the patient's PCR (e.g. birth certificate for minor child, Medical Power of Attorney or Advance Health Care Directive, court order, etc.)*

D. Your name and signature (REQUIRED):

- By signing this document, I am authorizing BHFD to use or disclose my Patient Care Report (PCR) which may contain personal and medical information collected in relation to the Emergency Medical Service(s) provided by BHFD.
- On the basis of the foregoing, I execute the foregoing AUTHORIZATION FOR USE & DISCLOSURE OF PATIENT CARE REPORT.
- The foregoing is true and correct of my own personal knowledge. I declare under penalty of perjury that the foregoing is true and correct.

Executed at: _____ _____

(City, State) Date

_____ _____

Signature Printed Name

E. Identity Verification (REQUIRED) – Please provide one of the following:

☐ Attached is a copy of my government-issued photo identification which shows my signature.

If patient's name and/or date of birth on the patient care report (PCR) are discrepant with the photo identification provided, two forms of photo identification will be required. If two forms of photo identification are not available, one form of photo identification and a notary will be required.

or

☐ No photo identification is attached but my signature has been notarized below.

NOTARIZATION REQUIRED COMPLYING WITH CALIFORNIA GOVERNMENT CODE SECTION 1031.1
STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

On _____, before me, _____, Notary Public

Personally appeared _____
Who proved to me on basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity (ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf on which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

[Place Seal and/or Stamp above] **Signature of Notary Public**

Please return this form and supporting documents to either of the following:

BHFD
Attn: EMS Records Custodian
445 N. Rexford Dr.
Beverly Hills, CA 90210

OR

Email: BHFDRecords@beverlyhills.org

Fax: (310) 278-2449

**For questions or assistance in completing this form, please contact us at (310) 281-2700.*