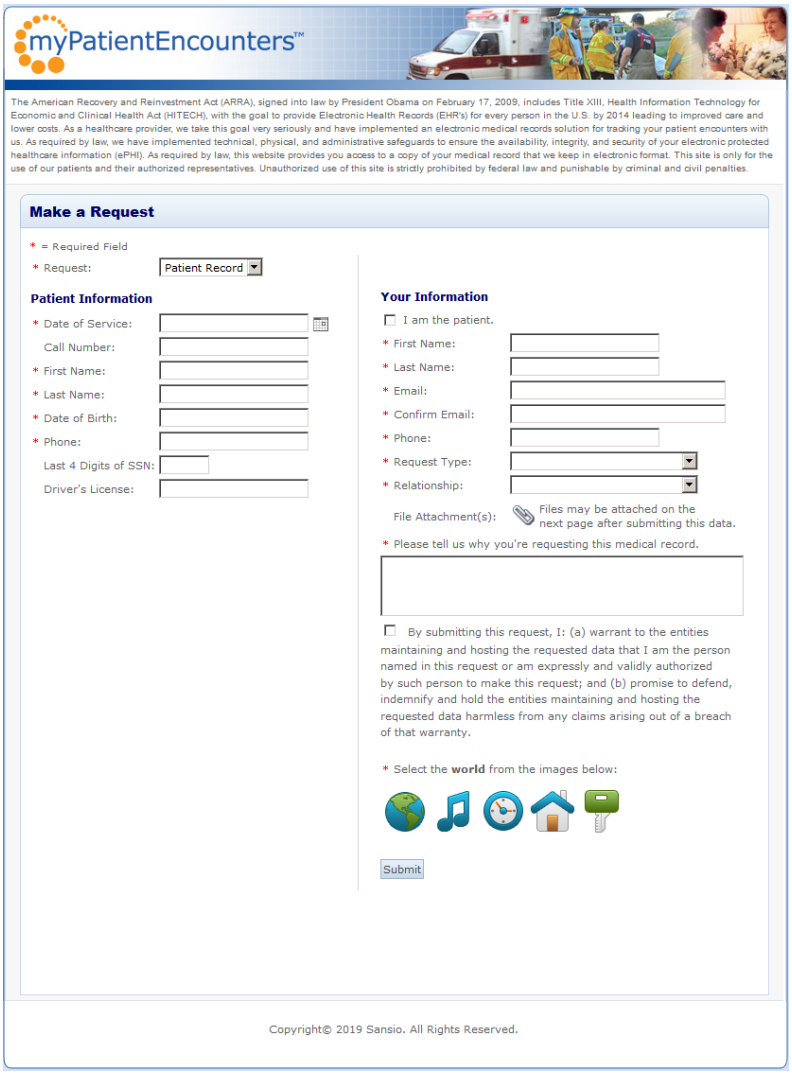
FDNY EMS PATIENT RECORD ACCESS WEB SERVICE

Instructions

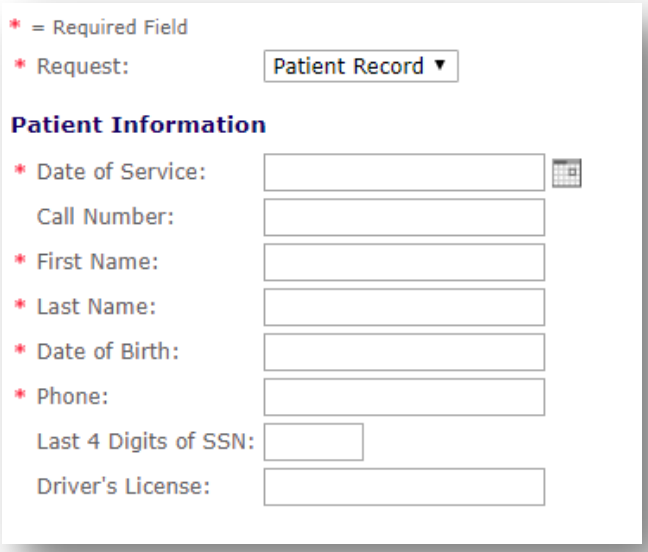
Follow these step-by- step instructions to submit your request online through the "myPatientEncounters" link below. To submit an FDNY Ambulance Pre-hospital Care Report request to the Fire Department of the City of New York, please use your web browser to navigate to the following URL:

https://fdny.mypatientencounters.com/myrecord

STEP 1 - When you click on the link the following page will open up.



STEP 2.
Please complete the following required **Patient Information** fields denoted by the *

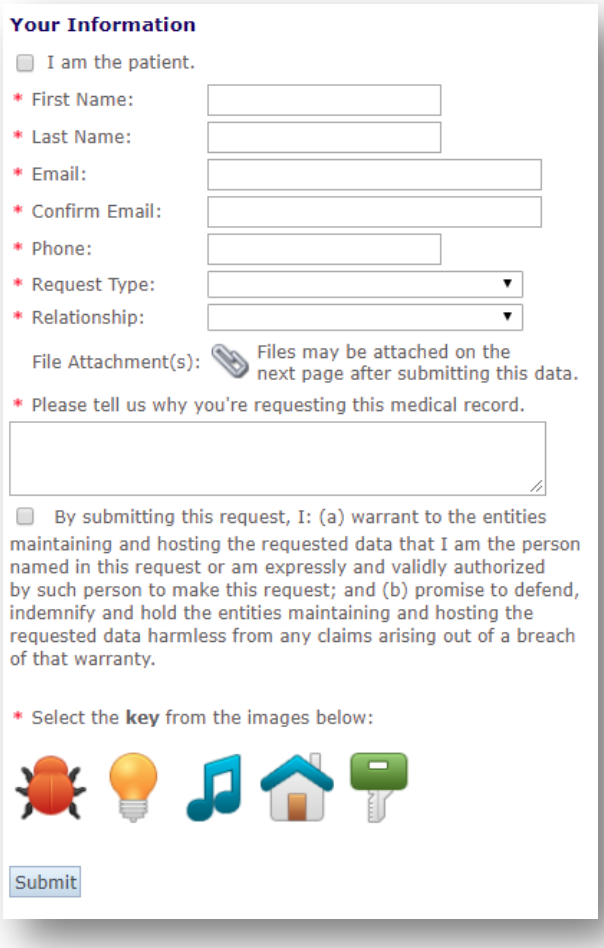


STEP 3.
Please complete the following information based on the requestor. If you are the patient, check the - **I am the patient -** box, and your information will copy from the **Patient Information** section.

The following documents are required to be attached 📎 for the request to be fulfilled (which will be attached on the next screen after submitting the demographic information):

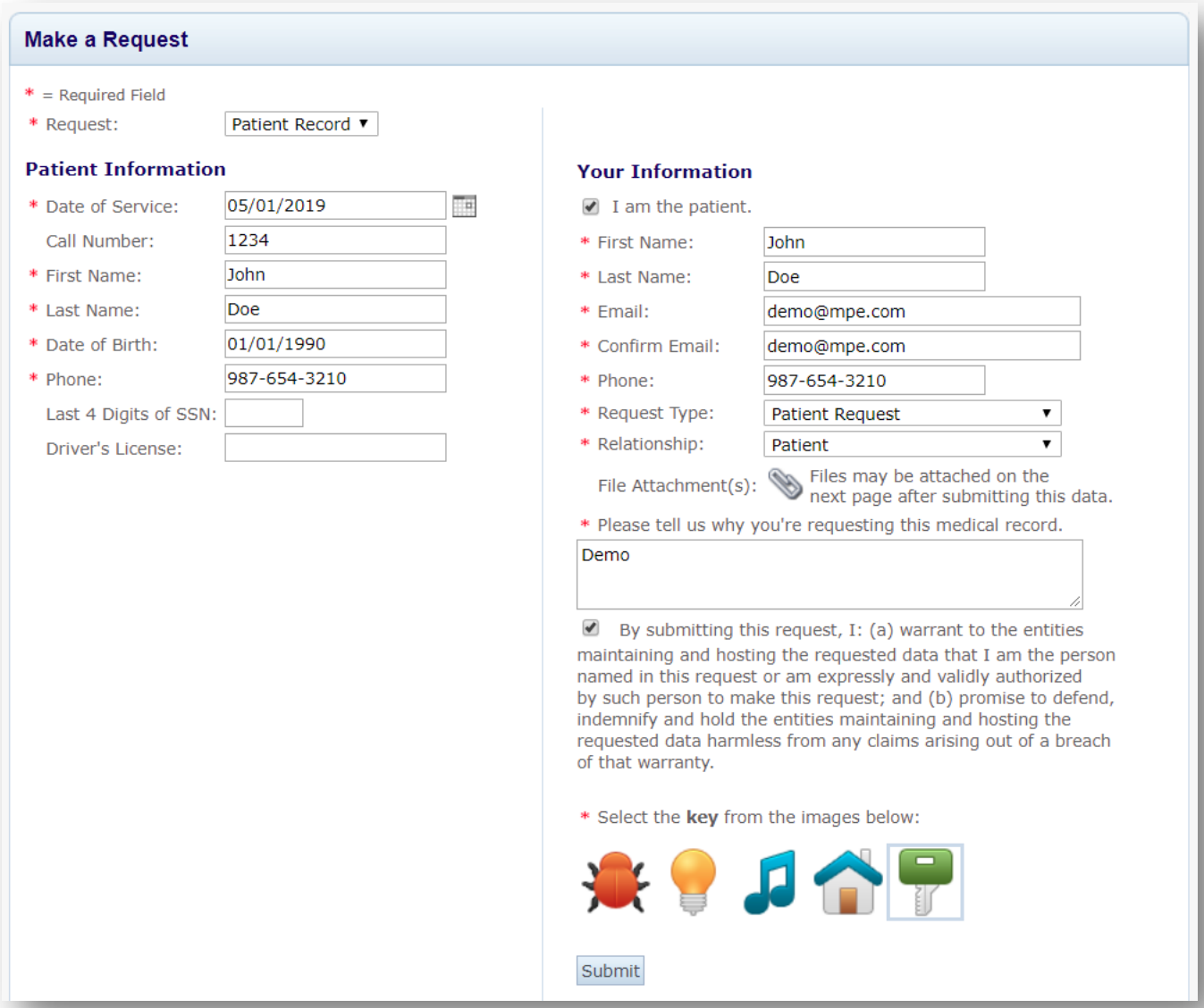
(1) HIPAA Form and the ACR Request Form (Page 8 and 9); and
(2) A good-quality photocopy of the signatory's valid (unexpired) government-issued photo ID that clearly shows the signature such as:
- Driver license; or
- Government issued non-driver photo-ID card; or
- Passport or Passport Card
- Government issued employment card ; or
- U.S. Military issued photo-ID.

If the requestor does not have a government-issued photo ID, then FDNY will accept two (2) of the following items:
- Utility or telephone bills; and
- Letter from a government agency dated within the last six (6) months.



STEP 4.
Select the **BOLDED** object from the picture options below, and select Submit when complete.

A completed form should look like the following sample:



Make a Request

* = Required Field

* Request: Patient Record

Patient Information

* Date of Service: 05/01/2019
Call Number: 1234
* First Name: John
* Last Name: Doe
* Date of Birth: 01/01/1990
* Phone: 987-654-3210
Last 4 Digits of SSN:
Driver's License:

Your Information

I am the patient.

* First Name: John
* Last Name: Doe
* Email: demo@mpe.com
* Confirm Email: demo@mpe.com
* Phone: 987-654-3210
* Request Type: Patient Request
* Relationship: Patient

File Attachment(s): Files may be attached on the next page after submitting this data.

* Please tell us why you're requesting this medical record.

Demo

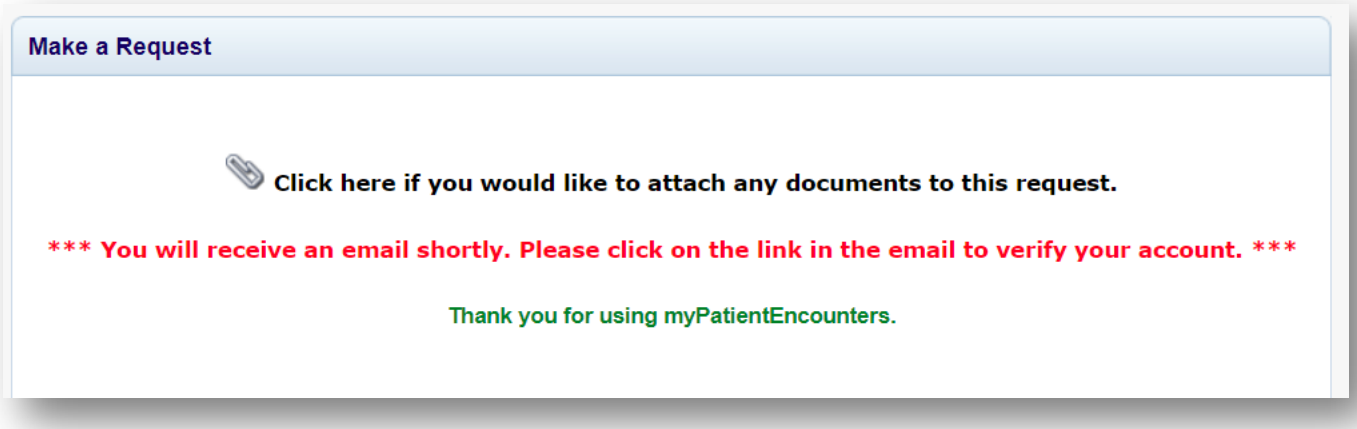
By submitting this request, I: (a) warrant to the entities maintaining and hosting the requested data that I am the person named in this request or am expressly and validly authorized by such person to make this request; and (b) promise to defend, indemnify and hold the entities maintaining and hosting the requested data harmless from any claims arising out of a breach of that warranty.

* Select the **key** from the images below:

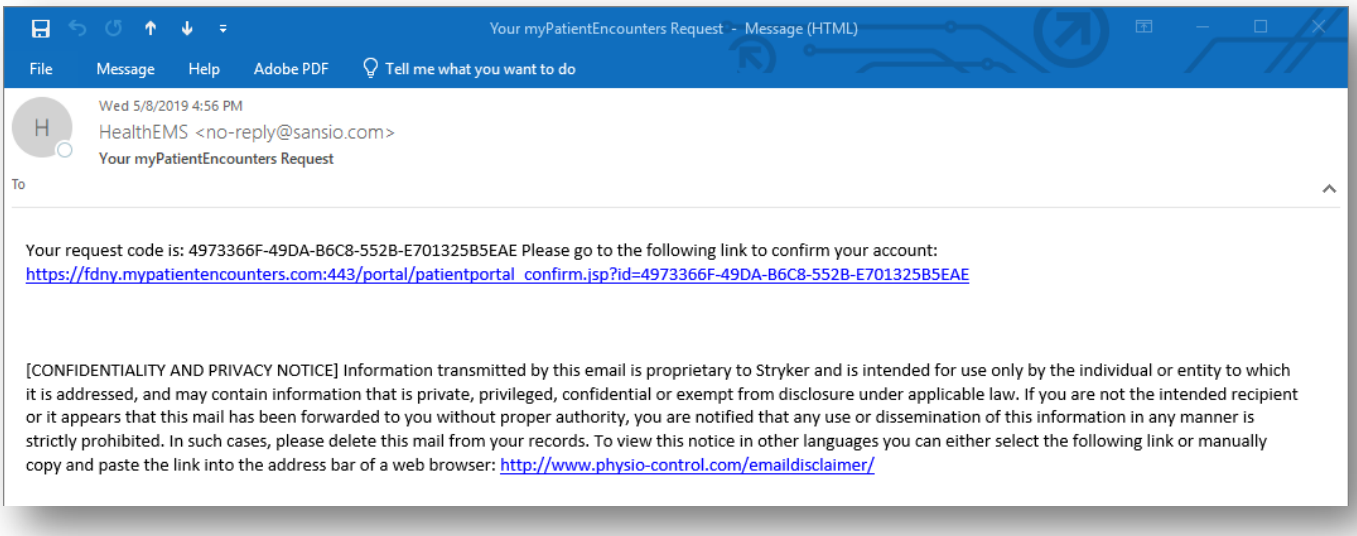
Submit

After submitting a request, an automated email with a UNIQUE request code will be sent to the provided email address.
*The email will be sent from: **no-reply@sansio.com**

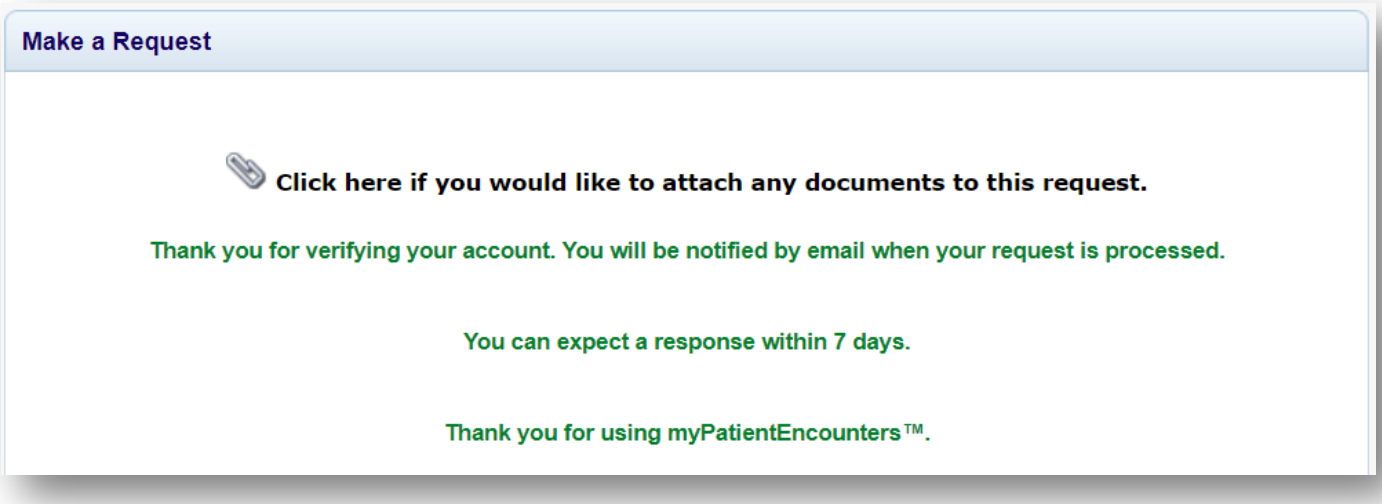
STEP 5. Please attach required form/document files on this page:



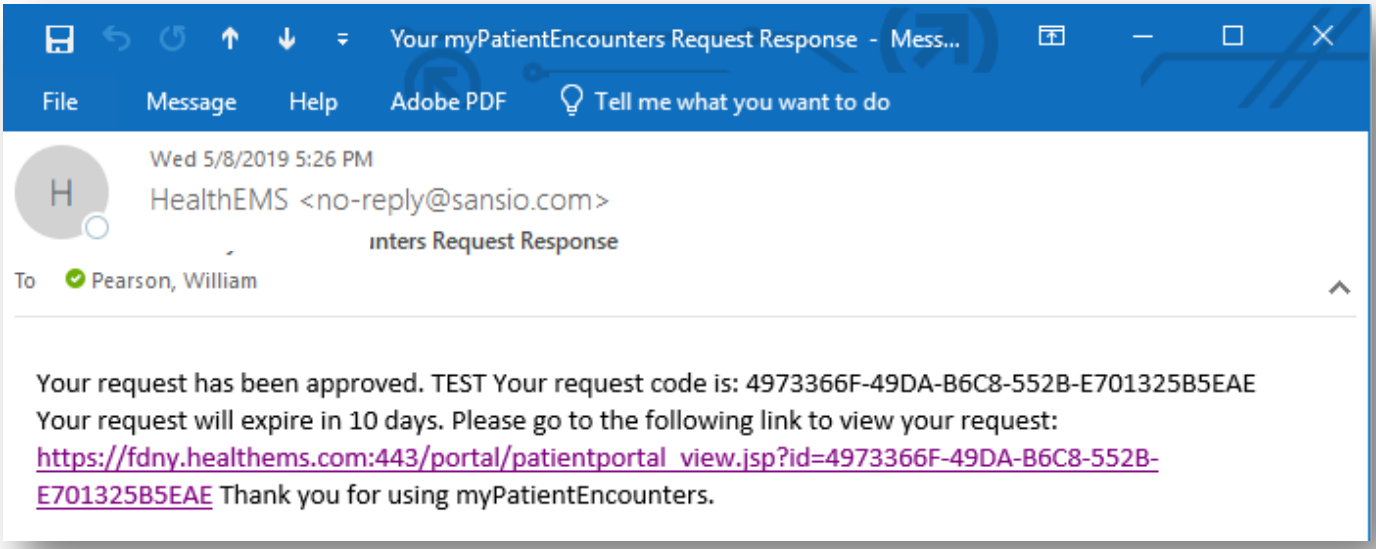
STEP 6. Please select the hyperlink to verify your request.



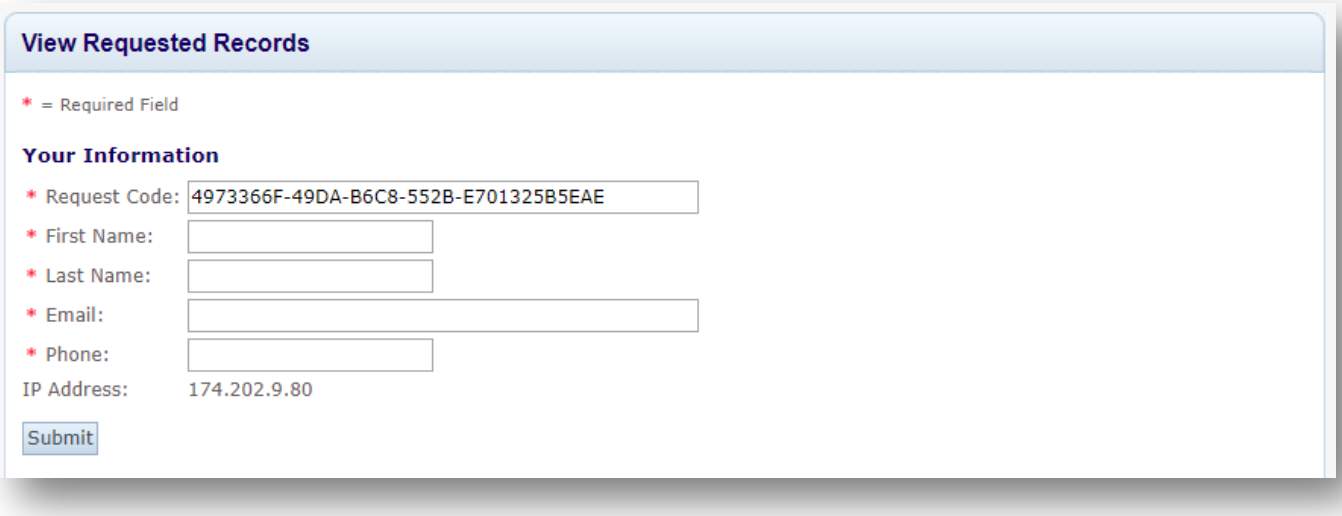
After selecting the hyperlink from the email, you will be directed to the following URL, confirming activation of your Electronic Health Record request.



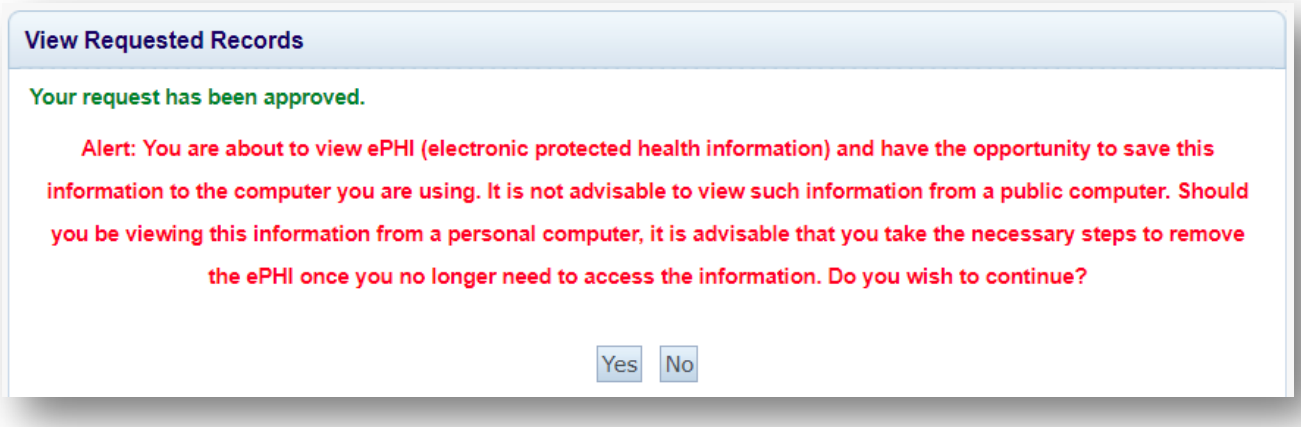
Once FDNY processes the request, you will receive a confirmation email with a hyperlink to access the requested Electronic Health Record.



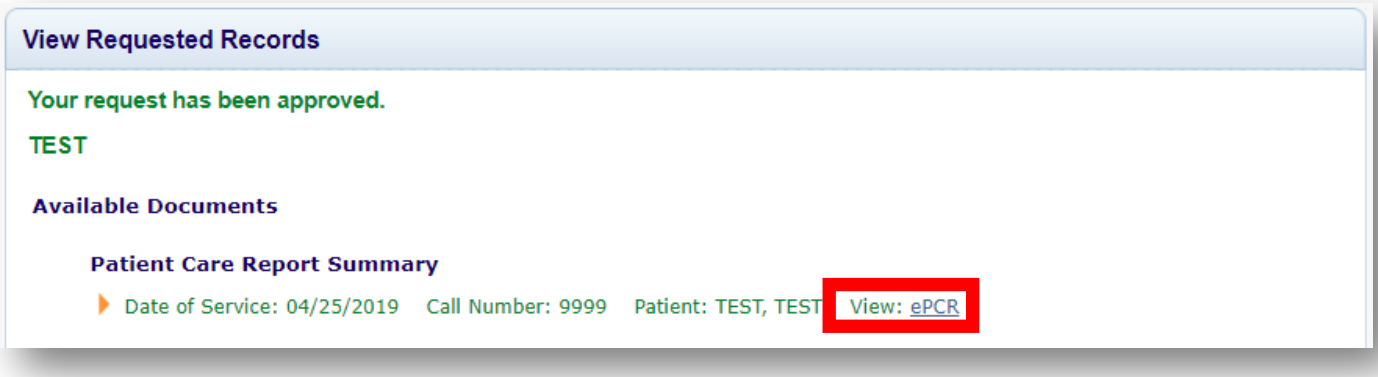
STEP 7. Please enter the required information below.



After hitting **Submit**, a notification will appear alerting you that you are about to view ePHI.



STEP 8. Select the **ePCR** hyperlink to view the PDF version of the Electronic Health Record. You can print or save the pdf.



FDNY HIPAA AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

THIS FORM MAY NOT BE USED FOR RESEARCH, MARKETING, FUNDRAISING OR PUBLIC RELATIONS

PATIENT NAME	DATE OF BIRTH	PATIENT SSN (LAST 4 DIGITS ONLY)
PATIENT ADDRESS	WTC HP ID # (IF APPLICABLE)	TELEPHONE #

NAME OF/HEALTH PROVIDER(S) AUTHORIZED TO RELEASE INFORMATION	**SPECIFIC INFORMATION TO BE RELEASED** (*If the box is checked you are authorizing the release of that type of information. If the box is not checked we may be unable to process your request*):
NAME AND ADDRESS OF PERSON OR ENTITY TO WHOM INFORMATION WILL BE SENT	☐ Medical Information requested: _____ ☐ Treatment dates from: _____ to _____ ☐ Entire Medical Record, including patient histories, office notes, (except psychotherapy notes), test results, radiology studies, films, and referral consults, billing records (if applicable), insurance records (if applicable), and records sent to you by other health care providers. **Include:** ☐ Alcohol and/or Substance Abuse Information ☐ Genetic ☐ HIV/AIDS information ☐ Mental Health Information ☐ Other (please specify): _____

Authorization to Discuss Health Information

By initialing here _____ I authorize _____to discuss my health information with my attorney,
(*Your Initials*) (*Name of individual healthcare provider*)

or a government agency listed here: _____.
(*Attorney/Firm Name or Governmental Agency Name*)

REASON FOR RELEASE OF INFORMATION:	WHEN WILL THIS AUTHORIZATON EXPIRE? (Please check one)
☐ Legal Matter ☐ At request of Individual ☐ Other (please specify):_____	☐ Event:_____ ☐ On this date: _____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to ALCOHOL or SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH, and/or CONFIDENTIAL HIV/AIDS RELATED INFORMATION, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, FDNY cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a FDNY Authorization Form for Release of Protected Health Information Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that FDNY has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the FDNY HIPAA Privacy Officer or the Bureau processing this request.

I have read this form and all my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above:

If not the patient, name of person signing form:	Authority to sign on behalf of patient:
Signature:	Date:

FIRE DEPARTMENT – CITY OF NEW YORK

Public Records Unit / PCR Section

9 MetroTech Center
Brooklyn, New York 11201-3857
(718) 999-1167

Pre-Hospital Care Report (PCR)

Request Form

SECTION A CUSTOMER INFORMATION

Please print your address and contact telephone number.

Name _____ Telephone Number _____

Address _____

State _____ Zip Code _____

Note: Mail your request to the address above. Please make sure you complete this form and attach all required documents as specified below. Enclose a self-addressed envelope (with a postal stamp).

SECTION B PATIENT INFORMATION

Please carefully read the instructions below and print the required patient's information.

Name of Patient: _____

Incident / Date: ____/____/____

Incident / Time: _____: _____ **Please check only one box:** **AM** ☐ **PM** ☐

Incident / Location: _____

Incident / Borough: _____

Hospital taken to: _____

Note: If the patient was not taken to a hospital, please indicate if he/she refused treatment or was treated at the scene on the line above.

Is the patient a minor (please check only one box)? **YES** ☐ **NO** ☐

Date of Birth: _____/_____/_____

Last 4 digits of Social Security Number: _____

If you have the PCR, please provide PCR number: _____

What is the requester's relationship to the patient (please check only one box below)?

☐ **Self / Patient** ☐ **Parent / Guardian** ☐ **Executor / Administrator of Estate** ☐ **Other** _____

CUSTOMER – PLEASE READ AND SUBMIT THE REQUIRED ITEM(S) BELOW

- A copy of a valid proof of identity in the request. One (1) of the following forms of valid photo-ID is acceptable: Driver license /New York State or City issued non-driver photo-ID card /Passport /U.S. Military issued photo-ID.
- Proof of Guardianship or Parental Status, if the patient is a minor. Acceptable proof would be a copy of the patient's birth certificate or a court document showing custody / guardianship.
- Proof that a court has appointed you Administrator of the Estate, if the patient is deceased.

You may also request the record online at: https://fdny.mypatientencounters.com/myrecord