CONGERS–VALLEY COTTAGE VOLUNTEER AMBULANCE CORPS, INC.

PO BOX 164 CONGERS, NEW YORK, 10920

MEDICAL RECORD REQUEST

Please type or print clearly

Date:_____

WHO IS MAKING THIS REQUEST?

- ☐ PATIENT
- ☐ PATIENT REPRESENTATIVE

NAME:_____
COMPANY:_____
ADDRESS:_____
_____
CITY:_____STATE:_____ZIP:_____
PHONE:_____
FAX:_____
EMAIL:_____

INCIDENT DATE:_____
INCIDENT LOCATION:_____
_____
PATIENT NAME:_____
PATIENT DATE OF BIRTH:_____

Requests must include a HIPAA Release form completed and signed by the patient. If the release is completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please include a description and documentation that grants that authority.

PLEASE SUBMIT THIS REQUEST BY MAILING IT TO:

PRIVACY OFFICER
CVCVAC
PO BOX 164
CONGERS, NY 10920

WE DO NOT ACCEPT RECORD REQUESTS BY EMAIL OR FAX