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:
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:

*** You will receive an email shortly. Please click on the link in the email to verify your account. ***

Thank you for using myPatientEncounters.

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

Your request code is: 4973366F-49DA-B6C8-552B-7E0132585EAE Please go to the following link to confirm your account:
https://femymypatientencounters.com/443/portal/patientportal.confirm.jsp?Id=4973366F-49DA-B6C8-552B-7E0132585EAE

[CONFIDENTIALITY AND PRIVACY NOTICE] Information transmitted by this email is proprietary to Stryker and is intended for use only by the individual or entity to which it is addressed, and may contain information that is private, privileged, confidential or exempt from disclosure under applicable law. If you are not the intended recipient or it appears that this mail has been forwarded to you without proper authority, you are notified that any use or dissemination of this information in any manner is strictly prohibited. In such cases, please delete this mail from your records. To view this notice in other languages you can either select the following link or manually copy and paste the link into the address bar of a web browser: http://www.physio-control.com/emaildisclaimer/
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.

Your request has been approved. TEST Your request code is: 4973366F-49DA-B6C8-552B-E701325B5EAE Your request will expire in 10 days. Please go to the following link to view your request: https://fdny.healthems.com:443/portal/patientportal_view.jsp?id=4973366F-49DA-B6C8-552B-E701325B5EAE Thank you for using myPatientEncounters.
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

<table>
<thead>
<tr>
<th>FIELD</th>
<th>INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT NAME</td>
<td></td>
</tr>
<tr>
<td>DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>PATIENT SSN (LAST 4 DIGITS ONLY)</td>
<td></td>
</tr>
<tr>
<td>PATIENT ADDRESS</td>
<td></td>
</tr>
<tr>
<td>WTC HP ID # (IF APPLICABLE)</td>
<td></td>
</tr>
<tr>
<td>TELEPHONE #</td>
<td></td>
</tr>
<tr>
<td>NAME OF/HEALTH PROVIDER(S) AUTHORIZED TO RELEASE INFORMATION</td>
<td>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):</td>
</tr>
<tr>
<td></td>
<td>□ Medical Information requested: ______________________</td>
</tr>
<tr>
<td></td>
<td>□ Treatment dates from: ___________________________ to ______________________</td>
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<tr>
<td></td>
<td>□ 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.</td>
</tr>
<tr>
<td></td>
<td>Include: □ Alcohol and/or Substance Abuse Information □ Genetic □ HIV/AIDS information □ Mental Health Information □ Other (please specify): ____________________________________________</td>
</tr>
<tr>
<td>NAME AND ADDRESS OF PERSON OR ENTITY TO WHOM INFORMATION WILL BE SENT</td>
<td></td>
</tr>
<tr>
<td>Authorization to Discuss Health Information</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>REASON FOR RELEASE OF INFORMATION:</td>
<td>WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)</td>
</tr>
<tr>
<td>□ Legal Matter  □ At request of Individual</td>
<td>□ Event: ___________________________ □ On this date: ___________________________</td>
</tr>
<tr>
<td>□ Other (please specify): ______________</td>
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</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>FIELD</th>
<th>INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>If not the patient, name of person signing form:</td>
<td>Authority to sign on behalf of patient:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>
SECTION A  
CUSTOMER INFORMATION
Please print the required information below.

Name

Telephone Number

Address

State    Zip Code

Note: Please make sure you complete this form and attach all required documents. Enclose a check or money order made payable to the NYC Fire Department and a stamped self-addressed envelope (with postage). Mail checks or money orders directly to the address and unit listed above. Only money orders or checks will be accepted for Requests (no exceptions). DO NOT MAIL CASH.

SECTION B  
PATIENT INFORMATION
Please carefully read the instructions below and print the required patient’s information.

Name of Patient: __________________________________________

Incident / Date: __/__/____

Incident / Time: ______: ______  AM ☐ PM ☐

Incident / Location: _______________________________________

Incident / Borough: _______________________________________

Hospital taken to: _________________________________________

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 ACR/PCR, please provide ACR/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

• An original notarized letter from the patient authorizing the release of this information.

• Proof of parental status or guardianship, if the patient is a minor. Acceptable proof is a copy of the patient’s birth certificate or a court document showing custody / guardianship.

• Proof that a court has appointed you executor or administrator of the patient’s estate, if the patient is deceased (Letters testamentary or letters of administration).

• Payment in the form of a check or money order in the amount of $2.25 for each report.