ECHO HOSE AMBULANCE

DIRECTIONS FOR REQUESTING PATIENT CARE REPORTS

If you are the patient:

Fill out the form below to request your patient care report. Please include all requested information including name, address and reason for request. The form must be signed by the patient.

If you are the patient's surrogate, i.e., attorney, power of attorney, parent, guardian, or spouse:

Fill out the form below for the patient care report. Please include all requested information including name of patient, your name, address and reason for request, and your position of surrogacy. The form must be signed by the surrogate.

All requests for patient care reports must be mailed to:

Echo Hose Ambulance
PO Box 213
Shelton, CT 06484
ATTN: Billing Department

A copy of valid driver's license or other picture form of government ID must be included with all requests. The ID must match the name of the person requesting the documentation.

ECHO HOSE AMBULANCE

Request for Patient Care Reports

<u>If you are the patient, please complete this section:</u>

Name: _____ Date of Birth: _____

Address: _____ Town: _____ State: _____Zip Code: _____

Reason for Request: _____

Signature: _____ Date: _____

If you are the patient's surrogate, i.e., attorney, power of attorney, parent, guardian or spouse, please complete the section below:

Patient Name: _____ Date of Birth: _____

Address: _____ Town: _____ State: _____Zip Code: _____

Reason for Request: _____

Your Name: _____ Position of surrogacy: _____

Signature: _____ Date: _____

<u>A copy of a valid driver's license or other picture of Government ID must be included with all requests. The ID must match the name of the person requesting the documentation:</u>

This form and ID should be mailed to:

Echo Hose Ambulance, PO Box 213, Shelton, CT 06484- ATTN: Billing Department