Essex-Windsor Emergency Medical Services
REQUEST AND AUTHORIZATION FOR RELEASE OF AMBULANCE CALL REPORT (ACR)

All requests for copies of Ambulance Call Reports must be submitted on this form. Completed forms should be forwarded to: **County of Essex, Privacy Officer, 360 Fairview Avenue West, Essex, Ontario N8M 1Y6**, Phone: 519-776-6441, Fax: 519-776-4455, E-mail: privacyofficer@countyofessex.on.ca OR **Essex-Windsor EMS Office, 920 Mercer Street, Windsor ON, N9A 1N6** Phone: 519-256-1315 Fax: 519-256-2053.
Proof of identification may be required from the individual granting authorization for release of their records.

Name of Person or Organization Requesting ACR: _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ E-mail: _____

Reason for Request: (check appropriate box)

- ❑ I am requesting disclosure of an ACR that relates to myself. *(Release Authorization signature required).*
- ❑ I am a Health Care Practitioner and require disclosure of the requested ACR for the purpose of providing health care to my patient. Explicit consent of my patient cannot be obtained in a timely fashion. *(Release authorization signature not required).*
- ❑ I am a representative of the Ministry of Health and Long-Term Care and require disclosure of the requested ACR for purposes relating to the discharge or exercise of EMS staff duties or powers under the *Ambulance Act*. *(Release authorization signature not required).*
- ❑ I am a representative of the individual to whom this request pertains and have been explicitly authorized by that individual to obtain a copy of the requested ACR. *(Release Authorization signature required).*
- ❑ Other _____
  (Release Authorization signature required).

AUTHORIZATION FOR RELEASE OF ACR

I, the undersigned, do hereby authorize Essex-Windsor EMS to release to the above specified Requester, the Ambulance Call Report (ACR) dated the _____ day of _____, 20__. The ACR pertains to _____ who was attended to by
(full name of person ACR pertains to)

Essex-Windsor EMS at or in the general vicinity of _____
(location of call)
at approximately _____ a.m./p.m.

- ❒ Please check here if you want the information sent to the specified Requester at the above address.
- ❒ Please check here if you want the information sent to an alternate address. *(specify below)*
- ❒ Please check here if you will be picking up the information at the Essex-Windsor EMS Office located at 920 Mercer Street, Windsor ON, N9A 1N6 Phone: 519-256-1315 Fax: 519-256-2053

Name of Person or Organization: _____

Address: _____ Postal Code: _____

E-mail Address: _____

By signing this Authorization, I am permitting the disclosure and sharing of my health and medical information contained on an ACR in the possession of Essex-Windsor EMS to the individual or organization specified as the Requester above.

_____ _____ _____
Signature Date Title, if legal representative*

* If you are submitting this request on behalf of this individual as their legal representative please provide documentation indicating your designation as such.

For Office Use Only

Identification Verified _____

PHIPA File No. _____

Release Approved

_____
Signature of Privacy Officer