Eastern PA MedCom, Inc.

Audio Record Request Form

1 Incident Information Request

Name

First Last

Name of Requesting Agency

Date of Request

MM / DD / YYYY

Date of Incident

MM / DD / YYYY

Time

HH : MM : SS AM AM/PM

Time of Incident

HH : MM : SS AM AM/PM

Unit(s) Involved

Hospital(s)

Purpose of Request

Eastern PA MedCom, Inc.

Audio Record Request Form

Record(s) Requested

Instructions for Completion:

1. All requests for copies of audio must be submitted utilizing this form.
2. All fields on this form must be completed; this is a mandatory requirement.
3. Released recordings are strictly for the use of EMS Medical Physicians and EMS Practitioners. Its use must comply with the non-disclosure statement below.
4. Audio requests must have the approval of an authorized representative of the Agency.
5. Release and use of a recording other than stated above shall be by court order only.
6. Recordings will only be released to agencies directly involved in the incident.
7. Requests may be submitted by mail, fax, hand delivery, or use of this electronic application. All audio requests must have written approval of the Eastern PA MedCom Operations Manager or his designee.
8. We require five (5) business days to complete your request.
9. Questions regarding requests for audio may be directed to the Operations Manager of Eastern PA MedCom or his designee.

Non-Disclosure Statement (to be completed upon pickup of requested and completed audio recordings).

MedCom recordings remain the property of Eastern PA MedCom, and copies are provided for the exclusive use of affiliated organizations for their internal use only. In response to your request, the requested audio recording is provided, and any reproduction, distribution, public release or any other similar use, other than in a court of law, pursuant to the ruling by the Pennsylvania Supreme Court, is strictly prohibited. Medical Communications audios are not public information for purposes of the Pennsylvania Right-to-know Act, and as such are not subject to public disclosure.
I hereby acknowledge receipt of the requested audio(s) subject to these restrictions and agree that the undersigned will indemnify Eastern PA MedCom and other party from any liability resulting from unauthorized disclosure. Additionally, I recognize Eastern PA MedCom right to pursue any appropriate sanctions against me if these recordings are improperly disclosed in any fashion without the prior consent of Eastern PA MedCom.

Email Authorization of person Accepting Copy

Signature of person Accepting Copy

Name of person Accepting Copy

Signature of Employee Releasing Copy

DO NOT COMPLETE BELOW THIS LINE
OFFICE USE ONLY

Date of Release

/ /

MM DD YYYY

Time of Release

: :

HH MM SS

Approved by

First Last

Submit to Medcom