Hudson Valley Regional
Emergency Medical Services Council

PHYSICIAN RELEASE FORM

33 Airport Center Drive ~ Suite 204, Second Floor

New Windsor, NY 12553 Phone: (845) 245-4292

AGENCY NAME	**RUN NUMBER**
DATE	**TIME**

THE SIGNING OF THIS DOCUMENT CONSITUTES THE ASSUMPTION OF LEGAL LIABILITY BY THE SIGNER FOR THE CARE AND TREATMENT OF THE PATIENT NAMED BELOW.

The physician whose signature appears below, by subscribing this instrument acknowledges that:

1. He/she is aware that the ambulance or rescue squad, named above, called to attend the below named patient, is operating under the coordination of the Hudson Valley Regional Emergency Medical Services (hereinafter referred to as HVREMS).

2. That the HVREMS supplies coordination for Basic and Advanced Life Support Systems in this geographical area.

3. That there is available to the ambulance or rescue squad, named above, a communication system capable of eliciting advice and instruction for the care and treatment of this patient by trained emergency physicians under a system of protocols and procedures subscribed to by physicians in the geographical area served by HVREMS.

4. That the undersigned physician assumes full responsibility for the care and treatment of the patient named below and by his/her signature agrees to hereby forever release and discharge HVREMS, its agents, servants or employees from any cause of action whatsoever, including but not limited to, any action ever as a defendant in a lawsuit brought by the patient or his/hers heirs, executors, administrators or assigns against said HVREMS and/or the ambulance or rescue squad named above, by reason of the care and treatment tendered to said patient under the orders and control of said undersigned physician.

WARNING: THIS IS AN ASSUMPTION OF LEGAL RESPONSIBILITY FOR CARE OF THIS PATIENT AND AN INDEMNIFICAITON TO AND RELEASE OF HVREMS AND THE ATTENDING AGENCY.

IN WITNES WHEREOF, I have hereunto set my and seal this _____day of _____, 20_____.

PHYSICIAN SIGNATURE		DATE
PHYSICIAN NAME (PRINT)		
Address:		
City	State	Zip Code
Patient Name		Address
City	State	Zip Code