

-EMERGENCY INFORMATION --- CONFIDENTIAL

*******EVACUATING COUNTY RESIDENTS IN NEED*******

****Municipality**

R = REQUIRED

**** ECRIN ID NUMBER: ___ - ___**

**** A / I / D: ___ Completes**

R. Date of Initial Completion: ___/___/___ R. Date of Last Update: ___/___/___

R. House: Own ___ Rent ___ MH/R Group Home ___ CYS Foster Care ___

R. Do you SPEAK English? Yes ___ No ___ R. Do you READ English? Yes ___ No ___
If the answer is NO, what is your **Native Language?** _____

Personal Information

R. Name: _____ **R. Phone:** _____
R. Address: _____ **R. Cell Phone:** _____
R. Township / City / Borough: _____ **E-mail:** _____
R. Zip Code: _____ **R. Date of Birth:** / /
R. Male: _____ **Female:** _____

R. Mobility: Check if the answer is 'yes.'

- Confined to Bed
- Confined to Wheelchair
- Require Medical Support Equipment, Oxygen/Ventilator, or Other: _____
- Walk with Walker, Cane or Other: _____
- Hearing impairment
- Sight impairment
- Other Personal Situation: _____
- Without any Personal Means of Transportation
- Service Animal

R. I might not be able to evacuate without help due to a: Mental Disability, Mental Retardation, Autism, Alzheimer's or due to not being able to verbally respond. Yes ___ No ___

◆ These things make me afraid (Loud Noises, Sirens, Being Approached from Behind, etc.): _____

◆ This is where I would hide if I was fearful (Inside, Outside): _____

I must take **medicine** daily which is prescribed by my doctor. Yes ___ No ___

Primary Care Physician:

Name:

Telephone Number:

Address:

EMERGENCY CONTACT:

Name:

Phone:

Cell:

Address:

E-mail:

Relationship:

EMERGENCY CONTACT:

Name:

Phone:

Cell:

Address:

E-mail:

Relationship:

Do you have **pets** in the household needing evacuation? Yes ___ No ___

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**Privacy Information: Privacy of Health Information / HIPAA Disclosures in
Emergency Situations**

Question: May an emergency official make disclosures to public officials who are responding to any man-made or natural emergency?

Response: Yes. Various agencies and public officials will need protected health information to deal effectively with a man-made or natural emergency. To facilitate the communications that are essential to a quick and effective response to such events, HIPAA permits covered entities to disclose needed information to public officials in a variety of ways. Covered entities may disclose protected health information, without the individual's authorization, to a public health authority acting as authorized by law in response to a man-made or natural emergency see 45 CFR 164.512(b), (see 45 CFR 164.512(j), (see 45 CFR 164.512(f)); 45 CFR 164.512(k)(2)); or judicial and administrative proceedings (see 45 CFR 164.512(e)).

MY CONSENT

My Signature Below Authorizes Us to Share Information With:

*York County Human Services, Emergency Management, and other Individuals involved in entering data into ECRIN

*Fire

*Police

*Emergency Responders

*Emergency Officials

*Municipal Officials

My Signature Below Also Represents Agreement With the Following Statements:

Liability: Neither the County of York (or any of its elected officials, employees, agencies or departments), York County Planning Commission, your local Municipality nor any of the individuals or entities involved in the accumulation of data, entry of data or use of the data can assure the accuracy, completeness, or reliability of the information provided or the use of that information in an emergency situation. Under no circumstances shall the County of York nor the other entities as noted previously be liable to you, including claims of negligence, for any special, incidental, direct, indirect, punitive or consequential damages.

Information: I agree that you may retain my information and use it for emergency planning and response, effective from the date of my signature and continues until / if I submit a signed, dated notice to my local Municipal Office, to the attention of Emergency Management, requesting that they remove my information. I understand that my local Municipality may contact me to verify my information, and if I fail to respond, the Municipality may remove my name from the ECRIN service. I understand that I am also responsible for notifying my Municipality if I change my address.

X _____
(Signature or Authorized person)

X _____
(Witness)

X _____
DATE

X _____
Relationship

City, Borough, Township: