

# Clinton First Aid & Rescue Squad

48 Old Highway 22 P.O. Box 5265  
Clinton, New Jersey 08809  
(908) 735-4012 / Business  
(908) 735-7125 / Fax

To: Clinton First Aid and Rescue Squad

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date(s) of service with Clinton First Aid and Rescue Squad: \_\_\_\_\_

I hereby authorize Clinton First Aid and Rescue Squad to release or disclose any and all existing medical records regarding the above-named person's medical care, treatment, physical condition, and/or medical expenses related to the date(s) of service written above to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

These records are being requested for \_\_\_\_\_ and shall be used solely for that purpose. This authorization shall cease to be effective as when revoked by me in writing, or at the end of six months, whichever comes first.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

I understand that I have the right to revoke in writing my consent to this disclosure at any time by mailing the revocation to Clinton First Aid and Rescue Squad, P.O. Box 5265, Clinton, NJ 08809, except to the extent that Clinton already has taken action in reliance upon this authorization. I further understand that Clinton cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

Clinton First Aid and Rescue Squad and its employees or members  are /  are not authorized to discuss with the entity or person named above any aspect of the patient's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition.

Any copy of this document shall have the same authority as the original, and may be substituted in its place.

Dated this \_\_\_\_ day of \_\_\_\_\_, 2017

\_\_\_\_\_  
Printed Name: \_\_\_\_\_

If signed is a patient representative, please describe your relationship to the patient and your authority to act on his/her behalf:

\_\_\_\_\_  
\_\_\_\_\_