MILLTOWN RESCUE SQUAD, INC.
SOUTH MAIN STREET P.O. BOX 308 MILLTOWN, NJ 08850

HIPPA COMPLIANT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ SS# _____

Date of Service: _____ Date of Birth: _____

Patient Address: _____ Call Location: _____

_____ _____

I hereby authorize Milltown Rescue Squad, Inc to release or disclose ANY AND ALL RECORDS IN THEIR POSESSION pertaining to 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 I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the Milltown Rescue Squad, Inc. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire on the following dates: **6 months.**

I understand that my health records may include information pertaining to treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted disease, tuberculosis or genetics.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the Milltown Rescue Squad, Inc.

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

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Description of Representative's Authority Signature of Witness
(Witness signature required)