AUTHORIZATION TO DISCLOSE INDIVIDUALLY IDENTIFIABLE PROTECTED HEALTH INFORMATION (PHI)

This form complies with HIPAA

TO: City of Vineland Emergency Medical Service Division

Patient Name: ________________________________

Date of Birth: ________________________________

Date of Service: ______________________________

I, the above-named patient, or legal representative, authorize you or your staff to release the health information listed below:

The Vineland EMS Patient care report for my treatment on ____/____/20___

This authorization entitles you to release the above information to:

_____ **Me, the patient,**

OR

_____ **Name:** ____

Street Address: ___________________________________

City: _______________________ **State:** ___________ **Zip:** ____________

I understand that the information you are releasing may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), Human immunodeficiency virus (HIV), behavioral health services, medical health services, and treatment for drug or alcohol abuse.

This authorization expires _____ calendar days from the date of my signature below. If the preceding date is blank, this authorization expires 180 calendar days from the date of my signature below.

I may revoke this authorization before the above expiration date. If I do so, I will send my written request to Vineland EMS at 76 Howard Street, PO Box 1508, Vineland, NJ, 08362-1508. In the document stating my request to revoke this authorization I will include the date that I signed this form for your reference. I understand that my decision to revoke this authorization will not apply to information that has already been released by this authorization. I am also aware that my decision to revoke this authorization does not affect your release of my otherwise protected health information for my treatment, payment for your services, or your operations as permitted under the law.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and in that case, will no longer be protected by HIPAA. In other words when I allow my information to be seen by parties not required to keep it confidential it will no longer be protected by the privacy rules.

______________________________ ______________________________

Signature of Patient | Date Signed by Patient

______________________________ ______________________________

Signature of Authorized Representative
In Place of Patient | Date

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Printed Name of Authorized Representative

The above representative is authorized to sign in place of the patient because: ____________________

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