# SOUTH TOMS RIVER VOLUNTEER FIRST AID SQUAD

Proudly Serving South Toms River & Berkeley Township's Manitou Park
WWW.STRFAS.ORG

P.O. Box 57 · Beachwood, New Jersey 08722
Non-Emergency (732) 341-3339 · Emergency 9-1-1


## AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name: _____ Date of Birth: _____
Print: First, Middle, Last)

Patient Address: _____

City / State:_____ Zip Code:_____ Phone #:_____

1. **I authorize South Toms River Emergency Medical Services to disclose my medical records to:**

   Name: _____

   Address: _____

   City / State:_____ Zip Code:_____ Phone #:_____

2. **This authorization is limited to the following dates of service:**

   From: _____ To: _____

   *If exact dates are not known, please provide an approximate time frame.*

3. **Reason for Request to release of Patient Records:**

☐ My Request ☐ Legal Request ☐ Continuity of Care ☐ Other:_____

4. **Authorization:**

I hereby authorize South Toms River Emergency Medical Services to disclose the patient record as contacted in the Electronic Patient Care Report. I understand that such disclosure may include information of a more sensitive nature, such as records related to: mental or behavioral health, substance use disorder (drug or alcohol abuse), genetic diseases or testing, sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and birth control and abortion (family planning). I specifically authorize the disclosure of such sensitive health information to the person or insulation noted above.

I understand that my authorization will automatically expire six (6) months from the date of signature on this form. I understand that I have a right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and submit my written revocation to South Toms River Emergency Medical Services. I understand that the revolution will not apply to health information that has already been disclosed in response to this authorization.

I understand that this authorization shall operate as a complete release of liability to South Toms River Emergency Medical Services, officers, employees, and agents, for the disclosure of the health information as described above.

I understand that the health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and/or state law.

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Signing this authorization is voluntarily and I understand that South Toms River Emergency Medical Services may not condition treatment, payment or enrollment or eligibility for benefits on my signing or refusal to sign this authorization.

By signing below, I understand that I am authorizing South Toms River Emergency Medical Services to disclose the health information as described above.

_____ _____

**Signature of Patient or Patient's Legal Representative (as applicable)** **Date**

_____ _____

**Name of Patient's Legal Representative (print)** **Relation to Patient or Statement of Authority to act on the Patient's Behalf (i.e. spouse, parent, legal guardian).**

**Proof of legal right to request for such information must accompany this request in the event that someone other than the Patient is requesting such information to be released.**

**For patients requesting records on themselves, a copy of a valid driver's license or state-issued identification card must also accompany this request.**

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********DEPARTMENT USE ONLY********

Date Request Received: _____ Received by: _____

Medical Record Accessed by: _____

Accessed on Date: _____

Document Provided to requested by:

- ☐ Email
- ☐ Certified Mail
- ☐ Fax
- ☐ Print - If checked, document was released to: _____

*First & Last Name / Date*

*Providing Over 50 Years of Service Since 1963*