MORRIS MINUTE MEN
EMERGENCY MEDICAL SERVICES

# Authorization to Use or Disclose Protected Health Information

Patient Name: _____
Date of Birth: _____ Date(s) of service: _____

Organization Name: Morris Minute Men Emergency Medical Services
Organization Address: 97 Mill Road, Morris Plains, NJ 07950 // PO Box 192, Morris Plains, NJ 07950

I hereby authorize the Organization 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:

_____ The patient or _____
_____

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 from the date of execution of this form, whichever comes first.

I understand that the health information being used/disclosed may include information relating to genetics, the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted diseases, mental illness, tuberculosis, and drug and alcohol use, abuse, and disorders (42 C.F.R. 2). I authorize that disclosure.

In accordance with P.L. 2022, c. 51 ("Chapter 51"), I acknowledge my right to withhold consent to release information pertaining to reproductive health care services that were disclosed during my care. I ☐ **DO** ☐ **DO NOT** permit the release of information pertaining to reproductive health care services in the medical record.

I understand that I have the right to revoke in writing my consent to this disclosure at any time by mailing the revocation to the Organization at the address specified below, except to the extent that I cannot revoke any releases already taken in reliance upon this authorization. I further understand that the Organization 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 redisclosure by the recipient.

I hereby release the Organization and its officers, directors, trustees, employees, members, volunteers, agents, and related persons from all liability whatsoever associated with this request to release medical records for information. This release expires six months from the date below.

The Organization 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 _____, _____

Signature: _____

Printed Name: _____

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

If patient is a minor: ☐ Parent ☐ Legal Guardian ☐ Self

If patient is an adult: ☐ Court-Appointed Guardian
- ☐ Durable medical power of attorney to authorize disclosure of health information on behalf of the patient (attach form and highlight relevant permission)
- ☐ Health care proxy (attach form and highlight relevant permission)
- ☐ Administrator or executor of the deceased patient's estate (attach death certificate and letter of administration from Surrogate's Court)