Marlboro First Aid Squad
P.O. Box 128
Marlboro, NJ 07746
(732) 536-1166

To: _____
Patient Name: _____ Date of Birth: _____
Social Security Number: _____ Social Security Number: _____
Date(s) of service: _____

I hereby authorize _____ 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, 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 _____, except to the extent that _____ already has taken action in reliance upon this authorization. I further understand that _____ 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.

_____ 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 _____, 2018

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 surrogate's documentation)

State of _____ *County of* _____

Sworn and Subscribed before me this _____ *day of* _____, *2018*

By: _____

Print Name _____

Notary Public or other officer authorized to take and certify acknowledgments and administer oaths