JACKSON TOWNSHIP EMERGENCY MEDICAL SERVICES
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the Jackson Township First Aid Squad d/b/a Jackson Township Emergency Medical Services to release the following health information:

_____

_____

To:

_____

(Name and Title or facility name to receive health information)

_____ _____ _____

(Street address, City, State, Zip Code) (Telephone Number) (Fax Number)

For the following purposes: _____

_____

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identified health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that the health information being used / disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease / infections and drug and alcohol disorders.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- **A copy of this form is valid as an original.**

Signed by Patient: Date:

_____ _____

Or Signed by Personal Representative: Date:

_____ _____

Personal Representative Printed Name & Address: On Behalf of:

_____ _____

Name of Patient

_____

(Street address, City, State, Zip code)

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE ATTACHED_____

(VALID STATE ISSUED DRIVER'S LICENSE, VALID STATE ISSUED IDENTIFICATION CARD, BIRTH CERTIFICATE, ANY OTHER VALID GOVERNMENT ISSUED PHOTO IDENTIFICATION)

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

PERSONAL REPRESENTATIVE INFORMATION

WHAT LEGAL AUTHORITY DO YOU HAVE TO MAKE MEDICAL DECISIONS FOR THE PATIENT

☐ **PARENT**

☐ **GUARDIAN**

☐ **CONSERVATOR**

☐ **MEDICAL POWER OF ATTORNEY**

☐ **EXECUTOR OF WILL**

☐ **OTHER _____**

NOTE: ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIUDAL.