Vernon Emergency Medical Services

Authorization for Use of Disclosure of Protected Health Information

Name of Patient: _____ Address: _____

Date of Birth: _____ Last 4 of SS Number: _____ Date of Incident: _____

I authorize Vernon Emergency Medical Services, Inc. of Vernon Township, New Jersey to use and disclose the protected health information described below to the above-named patient or their representative:
_____(Name or Agency) at _____(Address).

In accordance to the Health Insurance Portability and Accountability Act [HIPAA], if this request is by a law enforcement agency, a patient/ legal guardian authorization is not needed under suspicions that the incident is: 1) "To report PHI to law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public." 2) "To report PHI that the covered entity', Vernon Emergency Medical Services, Inc., 'in good faith believes to be evidence of a crime that occurred on the premises of the covered entity". 3) "To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct." 4) "To report PHI to law enforcement when required by law to do so (such as reporting gunshots or stab wounds)." 5) "To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer…" - "The administrative request must include a written statement that the information requested is relevant…"

This authorization for release of information covers the period of healthcare from: _____ to _____.

Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental health, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)

OR

☐ I authorize the release of my complete health record with the exception of the following information:
(Select the health record NOT to be disclosed.)

☐ Mental Health
☐ Alcohol/ Drug abuse treatment
☐ Other (please specify) _____
☐ Communicable Diseases (including HIV and AIDS)

This medical information may be used by the person I authorize to receive this information for medical treatment of consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until _____, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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

Patient or Legal Guardian

Patient/ Guardian Name: _____ Date: _____

Patient/ Guardian Signature: _____ Relationship to the patient: _____

Non-Patient or Legal Guardian

Date: _____

Name_____ Signature_____ Title: _____

Company/Agency: _____ Phone Number:_____

Address: _____

*Upon signing the release, the requester understands that this request may encounter a donation fee.
*Upon full completion of this release, the requester should mail it to: Vernon Emergency Medical Services Attn: Chief Operations Officer at P.O. Box 911 Vernon New Jersey 07462 or by e-mail to records@vernonems.com