Laurel Lake Vol. Fire and Rescue: EMS Division
5436 Battle Lane / P.O. Box No. 349
Millville, NJ 08332
contact@llfr-ems.org (856) 825-6767

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This form is NOT for a patient/representative to request their OWN records. This is a release of PHI to a third party.

PATIENT INFORMATION

Patient's Name (Full Legal):	Date of Birth (MM/DD/YYYY):	Social Security Number:	
Patient's Street Address:	City:	State:	Zip:
Patient's Mailing Address:	City:	State:	Zip:

Relationship to Patient(Person Authorizing this Release):

☐ **Self**

☐ Parent (*For Minors Only*) ☐ Legal Guardian ☐ Power of Attorney/Agent (*Incapacitated Patients only*) ☐ Other

***** If Other than "Self", Complete the following: *****

Name_____ Relationship) _____ Phone Number_____

****Attach all required documents supporting legal request on behalf of patient, if patient is not requesting report. ****

I request and authorize LAUREL LAKE VOL. FIRE RESCUE: EMS to release the health care information of myself/the patient named above to:

Name(s) of Authorized Recipient(s):

This request and authorization applies to:

☐ **All health care information**
☐ Health Care Information relating to the following date(s)_____
☐ Other (Specify): _____
_____

☐ I specifically authorize the release of any records regarding drug, alcohol, or mental health treatment to the Recipient(s) listed above.

Read Before Authorizing:

- By submitting this form, I hereby voluntarily authorize Laurel Lake Fire and Rescue (LLFR) to release this medical record to the Recipient(s) noted above, to the extent I have indicated on this form in the appropriate fields.
- I have been offered, read, reviewed, and/or understand Laurel Lake Fire Rescue's current Notice of Privacy Practices.
- Understand that information used or disclosed may be subject to re-disclosure by the recipient(s) receiving it and may no longer be protected by state and/or federal confidentiality laws.
- I further understand and agree that LLFR, and its employees and/or agents, are not liable in any manner for the disclosure of information provided under this request.
- I understand that I have the right to revoke this authorization at any time. The revocation must be made in writing and will not affect information that has already been released.
- I also hereby certify as the applicant that all information listed in this application and any attached or supporting documents is true and factual to the best of my knowledge. I certify that I am either the patient, or I am lawfully entitled to authorize this disclosure.
- I understand that willful falsification of this application or unauthorized request attempts may lead to criminal and/or civil charges and/or fines.
- **This authorization shall expire immediately after the disclosure, or within 90 days, whichever is sooner.**

Signature _____ **Printed Name** _____ **DATE:** _____