Carlstadt Volunteer Ambulance Corps, Inc.

PO Box 84, Carlstadt, NJ 07072
(201) 438-8886

Authorization for Release of Protected Health Information

(45 C.F.R. §164.508(c) and 514(h))

Terms and conditions of this authorization – I understand that:

- By signing this document, I am authorizing the Carlstadt Ambulance Corps to use or disclose my Protected Health Information (PHI), for the purpose stated herein, which may contain personal, medical, and billing information collected in relation to the emergency medical service(s) provided by the Carlstadt Ambulance Corps
- The person(s)/organization(s) authorized from me or as otherwise specifically required or permitted by law
- I may revoke this authorization by providing written notice to Carlstadt Ambulance Corps, except to the extent that action has been taken in reliance upon this authorization.

1. Patient Information (All fields in this section are REQUIRED, unless otherwise noted)

Name: _____ Birth Date: _____

Email (optional):_____ SS: _____/_____/_____

Address: _____

Street Apt# City State Zip Code

Phone: (_____) _____-_____

2. Person/Organization authorized to receive the PHI – Please tell us who you are authorizing to receive your protected health information(PHI) by completing the information below. For "Relationship", please provide a general description such as "self", "spouse", or "attorney".

Name (required): _____ Relationship (required):_____

Phone (required): (_____) _____-_____ Email: _____

Address (required): _____

Street Apt# City State Zip Code

3. Description of information to be released – I hereby authorize Carlstadt Volunteer Ambulance Corps to release the following PHI:

Incident Date (required): _____ Time: _____

Incident Location: _____

Description (required): ☐ Prehospital Care Report (Run Report)

4. Signature of Patient, Parent or Guardian, or Personal Representative (All fields are REQUIRED*)

Name (Print): _____ Relationship: _____

Signature: _____ Date: _____

By signing this document, I declare under penalty of perjury that all statements contained in this form and accompanying document(s) are true and correct. Signature must original, no electronic signatures permitted.

***Required Documentation –** All parents, guardians, and personal representatives must submit copies of official documentation evidencing their authority to act on behalf of the patient (e.g. minor's birth certificate, Medical Power of Attorney or Advance Health Care Directive, court order granting guardianship, marriage or death certificate, etc.). All submitted documents are subject to verification.*

5. Identity Verification (45 C.F.R. § 164.514(h)) – You (the person identified in Section 4) must provide:

- A copy of your photo identification which shows your signature (e.g., State Driver's License, State ID Card, Passport, Matricula Consular, or City/State/Federal Employment ID Card).

Please return this form and supporting documents to:

BY MAIL:	IN PERSON:	EMAIL:
Carlstadt Volunteer Ambulance PO Box 84 Carlstadt, NJ 07072	Carlstadt Volunteer Ambulance c/o Carlstadt Borough Hall 500 Madison Street Carlstadt, NJ 07072	Reports@CarlstadtAmbulance.com

If you have questions or need additional information or assistance in completing this form, please contact us at the above address or call (201) 438-8886.