Edison Emergi Med

I, _____ authorize Edison Emergi Med, their administrative and clinical staff to (check all that apply):

- ❑ Use the following protected health information, and/o
- ❑ Disclose the following protected health information to:

Name: _____
Relationship:

- ❑ Wife
- ❑ Husband
- ❑ Son
- ❑ Daughter
- ❑ Other: _____

Address: _____

Telephone number: _____

This protected health information is being used or disclosed for the following purposes (circle one):

- ❑ So my family can understand my on going medical care
- ❑ So my family can have the right to ask about my medical care while in the hospital only
- ❑ Transfer of medical records to another physician
- ❑ All of the above

How may we contact you?

- ❑ Leave message on answering machine
- ❑ Cell phone: _____
- ❑ Work phone: _____
- ❑ Authorized person listed

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Edison Emergi Med
1813 Oak Tree Road
Edison, NJ 08820

I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or if my authorization was required for treatment provided by participating in a research study.

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.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive research-related treatment or treatment that I have requested for the purpose of disclosure to others.

_____ _____
Signature of Patient Date Date of Birth

_____ _____
Print Name of Patient Date Witness