To: South Branch Emergency Services, Inc
PO Box 207
Allentown PA 18105

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Date(s) of service with South Branch Emergency Services (SBES) / High Bridge Emergency Services / Clinton First Aid & Rescue Squad (circle one): _____

I hereby authorize South Branch Emergency Services to release or disclose any and all existing medical records regarding the above-named person's medical care, treatment, physical condition, and/or medical expenses related to the date(s) of service written above to:

These records are being requested for _____ and shall be used solely for that purpose. This authorization shall cease to be effective as when revoked by me in writing, or at the end of six months, whichever comes first.

I understand that the health information being used/disclosed may include information relating to the diagnosis and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease and drug and alcohol disorders.

I understand that I have the right to revoke in writing my consent to this disclosure at any time by mailing the revocation toSouth Branch Emergency Services, Inc., P.O. Box 5265, Clinton, NJ 08809, except to the extent that SBES already has taken action in reliance upon this authorization. I further understand that SBES cannot condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on my provision of this authorization.

I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. South Branch Emergency Services, Inc and its employees or members □ are / □ are not authorized to discuss with the entity or person named above any aspect of the patient's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition.

Any copy of this document shall have the same authority as the original, and may be substituted in its place.

Dated this ____ day of _____, 20__

_____

Printed Name: _____

If signed is a patient representative, please describe your relationship to the patient and your authority to act on his/her behalf:

_____

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