MORRIS COUNTY HEALTH DEPARTMENT
PATIENT AUTHORIZATION FORM

PATIENT NAME____DATE OF BIRTH ________________

I hereby authorize the Family Health Center/Peterson Lab/_______________________to disclose the following information:

____ Copy of Physical & Pap for Family Planning ____ Lab results

____ Immunizations ____ Other:________________

TO: Morris County Health Department for the following identified purposes:

____ At the patients request ____ Continuation of care ____ Legal

____ Insurance ____ Other :______________________________

1. The authorization will expire one year from the date this form is signed by the client.

2. I understand I have the right to revoke the authorization by delivering such revocation, in writing, to the disclosing entity, except to the extent it has acted in reliance thereon before notice of such revocation.

3. I understand, except as otherwise provided in this authorization, once the uses and disclosures have been made pursuant to this authorization, they may be subject to redisclosure by any recipient and no longer protected by Federal Privacy regulations.

4. The above named office or hospital may not condition treatment on my providing and signing this authorization.

   I understand that some Protected Health information may be subject to special protections pursuant to Federal and State laws. **By my initials on the line immediately prior to each of the specifically described records in this paragraph,** I authorize the Morris County Health Department to use or disclose records containing such information if they are otherwise included within the scope of this authorization. As to records used or disclosed pursuant to my initials in this paragraph, I understand that these records shall not be redisclosed without my express written permission. I understand that the records to be used or disclosed pursuant to this authorization **may** contain:

   ________ information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, (excluding psychotherapy notes)

   ________ records relating to participation in any federally assisted drug and alcohol abuse programs;

   ________ information relating to HIV testing, HIV status, or AIDS.

5. A photocopy of this authorization will be effective as the original.

____ ____________________

Signature of Patient Date

6/16/11