



Rita U. Goradia, M.D., F.A.A.F.P.

DIPLOMATE OF THE AMERICAN BOARD OF FAMILY PRACTICE
HARSHEM FAMILY PRACTICE & WOMEN'S HEALTH, P.C.

WELCOME TO OUR OFFICE.

PLEASE TAKE A FEW MINUTES TO FILL OUT THE FOLLOWING INFORMATION.

IF THERE ARE CHANGES IN ANY OF THE AREAS BELOW, PLEASE FILL OUT THOSE CHANGED AREAS:

PATIENT NAME _____ REFERRED BY _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ ALT. PHONE _____

OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____ CITY, STATE, ZIP _____

SEX MALE MARITAL STATUS _____ SPOUSE'S NAME _____

FEMALE

PHARMACY NAME & ADDRESS _____

INSURANCE COMPANY & ID _____

PERSON RESPONSIBLE FOR ACCOUNT _____

RESPONSIBLE PARTY'S RELATIONSHIP TO PATIENT _____

RESPONSIBLE PARTY'S ADDRESS _____

RESPONSIBLE PARTY'S DATE OF BIRTH _____

ANY KNOWN ALLERGIES _____

DISCLOSURE OF MEDICAL INFORMATION (PLEASE LIST NAMES OF PEOPLE YOU GRANT ACCESS TO YOUR
HEALTH INFORMATION) _____

IF THERE ARE NO CHANGES, PLEASE READ AND SIGN BELOW:

- I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO: **RITA U. GORADIA, MDPC**
- I UNDERSTAND THAT ANY BALANCE NOT PAID BY MY INSURANCE COMPANY FOR ANY REASON IS MY RESPONSIBILITY.
- STATEMENT FOR PATIENTS WITH NO INSURANCE: DR. GORADIA AND/OR DANCHEL ARE SEEING ME AT A DISCOUNTED RATE. I CURRENTLY HAVE NO HEALTH INSURANCE. DUE TO FINANCIAL DIFFICULTIES IT WOULD BE DIFFICULT FOR ME TO OBTAIN ADEQUATE MEDICAL CARE WITHOUT THIS DISCOUNTED RATE.
- HIPPA - I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.
- LABS AND STUDY RESULTS: IT IS YOUR RESPONSIBILITY TO SCHEDULE AND ATTEND FOLLOW-UP APPOINTMENTS WITHIN A MAXIMUM OF 2 WEEKS, UNLESS OTHERWISE NOTED, FOR ANY AND ALL RESULTS. ANY DELAY IN TREATMENT ARISING FROM YOUR DEVIATION FROM THIS RULE WILL BE YOUR RESPONSIBILITY.
- ALL MEDICARE PATIENTS: THIS IS AN ADVANCE BENEFICIARY FORM, STATING THAT YOU ARE RESPONSIBLE FOR YOUR LAB FEES (PLEASE INQUIRE IF YOU NEED THE AMOUNT FOR EACH LAB).

PRINT NAME: _____ DATE: _____

SIGNATURE: _____ (LIFETIME SIGNATURE)

1003 St. Georges Ave.
Rahway, NJ 07065
Tel: (732) 388-3006
Fax: (732) 388-9878

700 N. Broad St., Suite 102
Elizabeth, NJ 07208
Tel: (908) 469-1500
Fax: (908) 469-1501



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NAME _____ DATE OF BIRTH _____

GENERAL MEDICAL INFORMATION

Current medical problem / reason for today's visit: _____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap / laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

Previous surgeries or hospitalizations (including miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy, or nursing a child? YES NO

Do you smoke? YES NO If yes: Cigarettes Pipe Cigars # of years: _____ How much? _____

Do you regularly drink alcohol? YES NO If yes, how many ounces/beers per day? _____

Do you regularly drink coffee? YES NO If yes, how many cups per day? _____

Are you under a lot of pressure at work? YES NO If yes, please describe: _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following? (Check all that apply and fill out necessary details.)

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Kidney disease _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Dizzy spells _____ | <input type="checkbox"/> Shortness of breath _____ |
| <input type="checkbox"/> Heart attack _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> TB / lung disorder _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Ulcers _____ |
| <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Skin disorders _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Difficulty hearing _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Allergies or Eczema _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Cataracts _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Memory loss _____ | <input type="checkbox"/> Digestive problems _____ |
| <input type="checkbox"/> Blood in stool _____ | <input type="checkbox"/> Hemorrhoids _____ | <input type="checkbox"/> Frequent urinary infections _____ |
| <input type="checkbox"/> Other: _____ | | |

Hepatitis C risk factor:

- | | | |
|--|--|--|
| <input type="checkbox"/> Blood transfusion prior to 1992 | <input type="checkbox"/> Contact with blood / bodily fluid | <input type="checkbox"/> Shared razor / toothbrush |
| <input type="checkbox"/> IV drug use (1+ times) | <input type="checkbox"/> Tattoos | <input type="checkbox"/> Body piercing |

IMMUNIZATIONS

Please fill out the year you last received the following vaccines, if known:

- | | |
|-----------------|-----------------|
| Smallpox _____ | Tetanus _____ |
| Typhoid _____ | Polio _____ |
| Influenza _____ | Pneumonia _____ |
| Rubella _____ | Hepatitis _____ |

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	<input type="checkbox"/>					
Epilepsy	<input type="checkbox"/>					
Cancer	<input type="checkbox"/>					
Eczema / Psoriasis	<input type="checkbox"/>					
Heart attack / Stroke	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>					
Asthma	<input type="checkbox"/>					
Hay fever	<input type="checkbox"/>					

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NAME _____ DATE OF BIRTH _____

CULTURAL COMPETENCY

Do you have any visual, hearing, speech, learning, or physical impairment?

What language(s) do you speak, read, and write?

Do you have any religious or culture customs that the doctor should know about?

YES NO

If yes, please describe:

Advance Directives

Advance Directives is a provision of the federal and state-mandated Self-Determination Act enacted in 1990 allowing the patient to provide specific instruction and direction regarding his or her own medical care wishes if he or she becomes incapacitated. The patient-physician relationship provides a direct opportunity for you to discuss these types of decisions with your physician. Physicians need to ask and document in the medical record for all the patients who are 18 years of age or older.

Do you have a "living will" or Advance Directive?

YES NO

Would you like to know more about a living will?

YES NO

Please refer to the attached Parameters of Care Order sheet for further details.

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NAME _____ DATE OF BIRTH _____

PARAMETERS OF CARE ORDER

I. IN THE EVENT OF CARDIO/PULMONARY ARREST:

- FULL RESUCITATION
- MODIFIED RESUCITATION

(WHEN A CARDIAC ARREST OCCURS DUE TO A POTENTIALLY REVERSIBLE EVENT THAT IS DEPENDENT ON RAPID RESPONSE, THE PATIENT MAY SPECIFY THE ACLS INTERVENTIONS THAT ARE PERMITTED. PROLONGED CARDIAC RESUCITATION IS NOT THE INTENT.)

PLEASE SPECIFY: _____

- NO RESUCITATION

II. MEDICAL MANAGEMENT (NOT IN THE EVENT OF CARDIO/PULMONARY ARREST)

- FULL AGGRESSIVE CARE (INCLUDES INTUBATION)
- MODIFIED CARE

PLEASE SPECIFY: _____

- AGGRESSIVE COMFORT CARE

PLEASE SPECIFY: _____

PATIENT HAS ADVANCE DIRECTIVE: YES NO

COPY IN CHART: YES NO

DISCUSSED WITH:	DATE:	TIME:	PHYSICIAN:
PATIENT:	DATE:	TIME:	NURSE:

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OFFICE POLICIES

Dear Patient,

Welcome to our office. Please take a moment to review our office policies. Please sign below to indicate you have been made aware and understand our office policies.

1. A co-payment is due EVERY medical visit.
2. All payments are due at time of service. We accept cash and checks only. Credit cards are NOT accepted.
3. All broken appointments will be charged a fee of \$25.00. Please inform us 24 hours in advance if you need to cancel or reschedule an appointment.
4. All returned payments and checks will be charged an additional fee of \$45.00. This will be passed on directly to you.
5. You are responsible for notifying us of any change in insurance, address, and telephone numbers.
6. Absolutely NO referrals or prescriptions will be called in or faxed. The patient will need to come to the office for a medical visit to justify the need for either of the above.
7. Absolutely NO test results will be discussed or relayed over the phone. As per HIPPA regulations, patients are required to make an appointment to come in and discuss with the doctor any and all results.
8. It is your responsibility to notify us if you need a referral to see a specialist. All urgent and non-urgent referrals will be prepared according to your insurance company's guidelines. We will not make, fax, or phone any referrals if you forget to obtain or take one for a specialist visit. Please advise us at least one week in advance before you visit a specialist.
9. There will be charges associated with filling out disability papers or any similar papers. Please contact the office staff to find out what charges are applicable to you. All disability papers require about 7 to 10 business days to be filled out completely.
10. We charge \$1.00 per page for copies of any medical records, as per the laws set forth by the Union County Medical Society.
11. We are required by law to collect 20% of Medicare payments and all pending deductibles or balances after your insurance has paid their part.
12. Any bills not paid within 30 days will be forwarded to the collection agency, and an additional minimum \$50.00 will be charged on these bills.

Please sign below to indicate that you have been made aware of and understand our office policies. Thank you.

Print Patient's Name _____

Patient / Guardian Signature _____

Date _____ / _____ / _____

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NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on 12/01/04 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us To:

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice

We Have The Right To:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATION: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility

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directories; your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify; a family member; your personal representative or another person responsible for our care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in our best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide the research proposal and established protocols to ensure the privacy of medical information.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency provided health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

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Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$1 for each page and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions. But if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

5. QUESTIONS AND COMPLAINTS

You have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U. S. Department of Health and Human Services. You may contact us to submit a complaint or submit request involving any of your rights in Section 4 of this notice by writing to the following address:

Rita U. Goradia, MDPC

1003 St. Georges Avenue, Rahway, NJ 07065

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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PROBLEM LIST

NAME _____ DATE OF BIRTH _____

DATE OF BIRTH _____

UPDATE AS OF _____

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MEDICATION RECORD

NAME _____ UPDATE AS OF _____

UPDATE AS OF _____

PHARMACY _____ TEL. # _____ FAX # _____

TEL. # _____ FAX # _____

ALLERGIES _____

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New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

**NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE**

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)
Registrant Name (Print)	Name (Print)
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

- Yes, I would like to participate in this program.
 No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date
---	------

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number
-------------------------------	--------------------	-----------------------

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -