capitalhealth

Medication History & Medication Benefits Consent

I give permission for Capital Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health.

Patient Signature: _____ Date: _____

New Jersey Immunization Information System (NJIIS)
CONSENT TO PARTICIPATE

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 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 www.njiis.nj.gov or at 609-826-4860.

There is no cost to participate in the 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): _____ Date: _____