EXHIBIT D

AUTHORIZATION FORM

Name of Patient:	**Date of Birth:**
Home Telephone:	**Social Security #:**
Home Address:	

1. I authorize the use and disclosure of the above named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

2. Specify information to be disclosed:

3. Type of Admission	**DATES**
_____ Inpatient	_____
_____ Emergency Room	_____
_____ Clinic/Physical Therapy	_____
_____ Other	_____

4. Specific Confidential Information Authorized for this Release:
I specifically authorize the use and/or disclosure of the type of highly confidential information listed below by signing my name next to the category indicated, if any such information will be used or disclosed pursuant to this authorization:

Psychotherapy Notes _____ Venereal Disease Information _____
Genetic Information _____ Drug and Alcohol Information_____
Tuberculosis Information_____ Mental Health Information_____
HIV/AIDS Related Information_____
(Including the fact that HIV test ordered, performed or reported, regardless of whether the results of such tests were positive or negative)

5. Release Information to:
[ ] Myself (the patient or authorized representative) [ ] To Organization/Individual Below
I authorize the use or disclosure of my health information to:

Organization: **Individual Name:**

Street Address:

Phone #:

6. Purpose of Release:

_____
_____
_____

I understand that I may refuse to sign or may revoke this authorization for any reason at any time and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify and expiration date, event or condition, this authorization will expire in six months.

I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. If I have questions about disclosure of my health information, I can contact the Montclair State University Privacy Officer. By my signature below, I hereby, knowingly and voluntarily, authorize _____ to use or disclose my health information in the manner described above.

Patient Signature: _____Date:_____

If the patient is a minor or otherwise unable to sign this Authorization, then obtain the signature of the legally authorized representative/individual below.

Description of Authority: _____

Signature: _____Date:_____