Consent Form

I hereby authorize the Harm Reduction Health (HRH) nurse at [name of agency] to provide nursing care and services including but not limited to HIV, STD, hepatitis, and TB testing, authorized treatments, vaccinations, wound care, and counseling services.

In connection with the foregoing, I understand that any information asked of me now or in the future shall be kept in records and/or files that are securely maintained by the [agency]. Any information contained in these records or files which **(1)** refers to me by name, or **(2)** otherwise discloses my identity, will be treated as confidential and made available only to [agency] staff and program administrators affiliated with the New Jersey Department of Health (DOH). Information collected from each patient may be used by the DOH and its contractors for health care oversight purposes. This information will not be made available to other individuals or agencies without my knowledge or written consent.

Client's Name: _____

Client's Signature: _____

Staff: _____

Date: _____