Exhibit A

WILLIAM PATERSON UNIVERSITY MEDICAL TREATMENT AUTHORIZATION FORM

I hereby authorize a licensed practitioner of the healing arts, acting within the scope of his or her practice under State law, to provide medical care that includes routine diagnostic procedures (e.g., x-rays, blood and urine tests) and medical treatment as necessary to my minor daughter/son/dependent,

Daughter/son/dependent's	First Name	Last Name	Date of birth
I understand that the consen and are valid only during th		•	le major surgical procedures
Child's physical or emotion	al health conditions	that the clinician should be	aware of:
Allergies, recurring illnesse	s, disabilities, chron	ic illnesses, etc.:	
medications			
medications			
Date of most recent tetanus	immunization:		
(If more than ten years ago,	a booster shot is rec	commended.)	
Also, Please disclose if you of New Jersey for a child hi		all required immunizations r	required by the State

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I cannot be reached, I give my consent for physicians and staff at University Health Services or other licensed practitioners of the healing arts to perform any necessary emergency treatment. I agree to the release of any records, medical, psychiatric or **HIPAA** related document necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I understand that University Health Services does not pay for such services and that it is my responsibility to pay the bill. As applicable, I am responsible to submit any claims to my health insurance company for reimbursement.

I also authorize William Paterson University to receive medical/billing information and submit it to the University's insurance carrier, if applicable.

I understand that I have the right to revoke this authorization, in writing, at any time by sending or delivering such written notification to the Vice President of Student Development, William Paterson University. However, my revocation will not be effective to the extent that any treatment has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.					
Name of Parent or Legal Guardian	Print Name of Parent of	or Legal Guardian	Date		
	tated otherwise in the William Paterson not provide medical insurance to cove				
Name of Parent or Legal Guardian	Print Name of Parent of	Print Name of Parent or Legal Guardian			
name	in this Program have been established, of the parent or legal guardian to	art of The William [chose appropriate conditions of the each child is			
Name and address of emergency conta	Phone No. (Home	e, Work & Cell)			
Name of family physician	Phone No.				
Parent's/ legal guardian's name and add	dress (please print) and Signature				
Parent's/ legal guardian's Health Insura	ance company				
Policy subscriber's name	Policy no.	Group no.	•		