



## Mental Health Practitioner – NJPMP Patient Consent Form

I, \_\_\_\_\_, am a new or current patient of

Name of Patient

\_\_\_\_\_ hereinafter “mental health practitioner”

Name of Mental Health Practitioner

at \_\_\_\_\_ hereinafter “licensed facility”

Name of Substance Abuse Treatment Center licensed by the Division  
of Mental Health and Addiction Services

and hereby authorize the mental health practitioner to obtain my prescription monitoring information to be used for the purpose of providing health care to me and/or verifying information. I further understand that my consent will be valid for the period of treatment by the mental health practitioner at the licensed facility or for one year, whichever is less. After one year, I understand that the mental health practitioner shall reobtain my consent to access my prescription monitoring information.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date