Manasquan Pediatrics

HIPPA & NJPMP AUTHORIZATION FORM

Acknowledgement of Privacy Practice Notices

I have viewed a copy of Manasquan Pediatrics Privacy Practice Notices.

_____ _____ _____ _____

Date Patient Name Birth date Signature

I, _____ hereby authorize Manasquan Pediatrics to use and or disclose any protected health information, (e.g. immunization records, lab reports, child's health status, etc.) to the following entities via telephone/fax/electronic/mail:

_____school/daycare/babysitter _____other healthcare providers/State of NJ

***Please list any exclusions*: _____**

Please contact me as stated below:
□ please leave a detailed message on my answering machine.
OR
□ please leave a message with the Doctors name and phone number only.

Written communication : Unless otherwise instructed written communication will be mailed to the home address on file.

***Designation of relatives, friends, or caregivers*:**

I agree that Manasquan Pediatrics may disclose certain health information to a family member, close friend, or caregiver because such person is involved with patients healthcare or payment relating to patients healthcare. In the case, Manasquan Pediatrics will only disclose information that is relevant to the person's involvement with the healthcare or payment relating to the healthcare.

I designate the following persons listed below as persons involved with the healthcare or payment relating to the healthcare for the purposes of Manasquan Pediatrics to make the type of disclosures listed above. I understand that I am not required to list anyone and that I may change this list at any time in writing.

Print Name/Relationship/DOB: _____
Telephone: _____
Print Name/Relationship/DOB: _____
Telephone: _____

_____ _____

Date Signature of Patient/Guardian

Rev. 11/30/2012