BRIELLE PEDIATRICS
HIPAA & NJPMP AUTHORIZATION

PATIENT NAME(S) BIRTHDATE(S)

_____ _____
_____ _____
_____ _____
_____ _____

I, _____ HEREBY AUTHORIZE BRIELLE 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 VOICEMAIL.

OR

___ PLEASE LEAVE A MESSAGE WITH 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 BRIELLE 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, BRIELLE PEDIATRICS WILL ONLY DISCLOSE INFORMATION THAT IS RELEVANT TO THE PERSON'S INVOLVEMENT WITH THE HEALTHCARE OR PAYMENT RELATING TO HEALTHCARE.

I DESIGNATE THE FOLLOWING PERSONS LISTED BELOW AS PERSONS INVOLVED WITH THE HEALTHCARE OR PAYMENT RELATING TO HEALTHCARE FOR THE PURPOSES OF BRIELLE 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 _____

SIGNATURE _____ DATE _____