HIPAA & NJPMP Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, authorize Point Pediatrics to use and/or disclose any protected information (immunization records, lab reports, child's health status, etc.)for **all of my children** 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:

_____ Leave a DETAILED MESSAGE on my answering machine

_____ Leave a message with the doctor's name and number ONLY

Designation of relatives, friends or caregivers:

I agree that Point Pediatrics may disclose certain health information to a family member, close friend, or caregiver because such person is involved with patient's healthcare or payment relating to patient's healthcare. Point 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 person(s) listed below as person(s) involved with the healthcare or payment relating to the healthcare for the purposes of Point Pediatrics to make the type of disclosure listed above. I understand I am not required to list anyone and that I may change this list at any time in writing.

NAME/RELATIONSHIP/DOB/PHONE: _____

NAME/RELATIONSHIP/DOB/PHONE: _____

_____ _____ ___/___/_____

Signature Phone Number Date

800 Rt 88 Suite 3
Point Pleasant, NJ 08742
P :732.714.1444 | F: 732.714.9664
WEBSITE: www.pointpediatrics.com

We are required by State and Federal laws, including the HIPAA rules, to safeguard general and health-related information about you. We have a Notice of Privacy Practices that explains how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

I acknowledge that I was offered a copy of our Notice of Privacy Practices. Copies are available on our website and personal copies can be requested from our staff. By signing below you are only acknowledging that you were offered or received a copy of the **Notice of Privacy Practices**. You may refuse to sign this acknowledgment if you wish. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment
I acknowledge that Point Pediatrics has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact: **Privacy Officer NJ Office of Civil Rights by calling 866-627-7748**. I also understand that I am entitled to receive updates upon request if Point Pediatrics amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient/patient's representative Relationship to patient

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For OFFICE USE ONLY
I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:
[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (Specify): _____

_____

_____ ___/___/_____
Name and Title of Employee Date

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Point PEDIATRICS