The
Pediatric Day Health Center
at Manchester

1770 Tobias Ave, Manchester, NJ 08759
Phone: 732-323-8400 • Fax: 732-323-8408

FAX COVER SHEET

DATE: 11-28-11

TO: Yasin Pediatrics

FAX NUMBER: 609-242-1906

FROM: Carol Belanger, BSN – Administrator ✓
Jane DePaola, BSN – Acting Director of Nursing
Jesse Alter, LSW – Director of Social Work
Kaila Kroeper, BA – Teacher/Activities

NUMBER OF PAGES: (Including Cover) 3

Comments: Please fax over Jamir Barnes (DOB: 11/1/10) immunization record - ours is incomplete. Attached is HIPPA release.

Thank you —
Carol

The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See 45 CFR 164.506 and the definition of "treatment" at 45 CFR 164.501.

NAME Javier, Barroa

PEDIATRIC DAY HEALTH CENTER
1770 TOBIAS AVE., MANCHESTER, NJ 08759

AUTHORIZATION

By signing this Authorization, I hereby direct the use or disclosure by **The Pediatric Day Health Center** certain medical information pertaining to me[1], my health or my health care.

1. This Authorization concerns the following medical information:
Immunizations, X-rays, blood tests, labs, therapies, hospitalizations, insurance and billing information, education, history, physical assessments, and rehabilitative therapy evaluations and treatment notes

2. This information may be used or disclosed by **healthcare providers, insurance providers, Ocean County Health Department, and rehab therapy providers**

   to (if a disclosure) **Pediatric Day Health Center at Manchester**

3. This authorization expires on **date of discharge** (date or event).

4. I understand that I have the right to revoke this Authorization at any time except to the extent that **The Pediatric Day Health Center** has already acted in reliance on the Authorization, or if the Authorization was obtained in order to obtain insurance coverage and the insurer has the legal the right to contest a claim under the coverage. In order to revoke this Authorization, I understand that I must provide a written revocation.

5. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

6. If the Authorization is being requested by **The Pediatric Day Health Center** so that **The Pediatric Day Health Center** can use the information described above for its own use or disclosure, **The Pediatric Day Health Center** may not condition treatment on obtaining this Authorization from you. I understand that I have the right to inspect and copy the information that is the subject of this Authorization. The Authorization is being requested by **The Pediatric Day Health Center** for the following purpose(s):
Continuity of care

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[1] In the event the resident no longer has decision making capacity, the provisions of this Authorization may be applied to the authorized representative(s) of the resident (e.g., individuals empowered to make health care related decisions pursuant to a valid power of attorney, advance directive or court appointed legal guardian) who is acting within the scope of his/her authority.

NAME Javier Barroa

Further, I understand that I have the right to refuse to sign this Authorization.

[The Pediatric Day Health Center will note if the use or disclosure will result in any renumeration.]

7. If the Authorization is being requested by **The Pediatric Day Health Center** so that **The Pediatric Day Health Center** can obtain medical information on you in order to carry out treatment, payment or health care operations from another provider, a health plan or health care clearinghouse **The Pediatric Day Health Center** may not condition treatment on obtaining this Authorization from you. I understand that I have the right to inspect and copy the information that is the subject of this Authorization. The Authorization is being requested by **The Pediatric Day Health Center** for the following purposes:

Continuity of care, administration of prescribed treatments and medications

Further, I understand that I have the right to refuse to sign this Authorization.

[Name] _____

[Signature] _____

[Date] _____

OR

[Authorized representative, if applicable]

X [Signature] _____

[Date] 9-2-11

[Relation to Patient] mother