NAME: _____

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

AUTHORIZATION

By signing this Authorization, I hereby direct the use or disclosure by **The Manchester Pediatric Medical Daycare** 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) **Manchester Pediatric Medical Daycare**

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 Manchester Pediatric Medical Daycare** 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 Manchester Pediatric Medical Daycare** so that **The Manchester Pediatric Medical Daycare** can use the information described

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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: _____

above for its own use or disclosure, **The Manchester Pediatric Medical Daycare** 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 **The Manchester Pediatric Medical Daycare** for the following purpose(s):

Continuity of care

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

[The Manchester Pediatric Medical Daycare will note if the use or disclosure will result in any remuneration.]

7. If the Authorization is being requested by **The Manchester Pediatric Medical Daycare** so that **The 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 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 Manchester Pediatric Medical Daycare** 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]

[Signature] _____

[Date] _____

[Relation to Patient] _____