



New York Primary Care

THE CHABLA FAMILY PRACTICE

Office: 212-568-8400

Fax: 212-927-5719

Make an appointment Today
639 W 185th Street
New York, NY 10033
www.nypcare.com

Authorization to Schedule Testing/Office Visits/Medical Information and Results of Progress or Prognosis

Patient Name: _____ Date of Birth ____/____/____

I authorize New York Primary Care Medicine, P.C to talk to the following people regarding my scheduling, office visits, medical information and results if I am unavailable.

Please Circle:

- ❖ No one other than myself
- ❖ My Spouse/Partner (name of Spouse/Partner):

- ❖ My Children (name of children):

Message on my answering machine/voicemail at the following number(s)/ or any other

Phone number:

I understand that this statement will remain in effect until I notify *New York Primary Care Medicine, P.C* in writing of any changes.

Patient Signature _____ Date _____

If Patient is a Minor:

Representative Name: _____ Relationship: _____

Representative Signature: _____