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

PATIENT INFORMATION

Name:

_____

Address:

_____

City, State, Zip Code:

_____

DOB:: _____ SS#: _____

Cell#: _____

RELEASED FROM:

New York Primary Care Medicine, P.C
639W 185th Street New York, N.Y 10033
Tel# :(212) 568-8400 Fax#: (212) 927-5719

COPIES RELEASED TO:

Name of Organization or Individual:

_____

Address:

_____

City, State, Zip Code:

_____

Phone#:_____

Fax#:_____

GENERAL INFORMATION

Type/Extent of Information

- ☐ All Records
- ☐ Labs
- ☐ X-rays/MRI/ (All diagnostic images)
- ☐ Selected Records Only (specific dates)

_____

Purpose/Need

- ☐ Further Treatment/ Changing Physicians
- ☐ Insurance Reasons
- ☐ Disability
- ☐ Other:_____

Specific Information (please list):

_____

_____

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW: I specifically consent to the release of data and information relating to: (check all that apply) Substance Abuse (Alcohol/D.A.) Mental Health (including psychological evaluation and treatment) HIV Related Information (AIDS related testing)
Patient Signature:

_____

Date:

_____

NOTICE: With respect to any substance abuse treatment information, mental health records, and/or communicable disease related information protected by State and Federal law and released pursuant to this authorization, the recipient understands that it is prohibited from making any further disclosure of this information without the specific written consent of the patient, or as otherwise permitted by law/regulation. This authorization shall be considered invalid after 6 months or 60 days with respect to State and federally protected records from the date of signature. I may revoke this authorization at any time by providing written notice of revocation. However, I may not revoke the authorization retroactively for information already released.
Patient Signature:

_____

Date:

_____

Legally Authorized Representative:

_____

Relationship:

_____

Witness:

_____