Niagara Primary Care and Urgent Care

3117 Military Road, Niagara Falls, NY 14304
Phone: 716-257-1254 Fax: 716-215-6170

Welcome to Our Practice!

We are dedicated to providing you with the kind of care that we would want for our own loved ones. To save time on the day of the appointment, read the following information and complete the enclosed registration forms.

Please arrive at least **30 minutes** before your scheduled time. Bring all of the forms and consent documents to your first visit if you haven't already mailed them to us. If you are unable to complete these forms before your visit, please try to arrive an hour before your scheduled time so we can fill out the forms with you.

Mail the completed forms to: Niagara Primary Care
3117 Military Road
Niagara Falls, NY 14304

Your appointment location is: Niagara Primary Care
3117 Military Road
Niagara Falls, NY 14304

Please remember to bring your:

1. Health insurance card
2. Drivers license or government-produced photo ID
3. List of your medications along with dosages

Patient Payment Information: We recommend you contact your insurance company regarding charges as it is the responsibility of the patient to obtain coverage and benefit information from their insurance carrier. Any insurance verification we provide is done as a courtesy and is not a guarantee of benefits, payment or your financial liability. Your financial liability can include your copay, deductible and coinsurance as determined by your insurance carrier and due at the time of service. If you do not have your payment, your visit may be rescheduled.

Medical Records: If you had a another primary care provider in the last 2 years AND if you had any lab work, x-rays, CT-scan, MRI or other procedures done, please contact the office as early as possible **before** your scheduled visit so we can obtain your medical records and findings ahead of time to minimize your wait time during your visit. Obtaining your records can take up to a few days.

Tests, Labs, Imaging and Referrals: After your first appointment, a follow up appointment with the provider is important and will be scheduled (in-person or Telehealth) to discuss and professionally interpret the results with the patient. It is the responsibility of the patient to contact our office to discuss the results over the phone if it is not possible to attend the follow up appointment. It is also the patient's responsibility to have results sent to us. Please contact our staff before your follow up visit to make sure that we received your results. *If the provider refers the patient to another facility or doctor, it is the patient's responsibility to contact the facility or the doctor to obtain an appointment.

Primary Care Registration Form

☐Dr. ☐Miss ☐Mr. ☐Mrs. ☐Ms. ☐Sir ☐ I'm a Jr. ☐ I'm a Sr.

Patient's Name: (Last) _____ (First) _____ (MI) _____

Mailing Address _____ City, State, ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

*Date of Birth (MM/DD/YYYY) _____ Sex: ☐ Male ☐ Female ☐ Other _____

Social Security Number _____ Primary Care Provider (PCP) _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

E-mail Address _____ ☐ I **want** to have access to the **patient portal**

Language _____ Race _____ Ethnicity _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Phone Number _____

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address _____ City; State; Zip:_____

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐ Self ☐ Another Patient ☐ Guarantor Check here if information is same as patient ☐

Responsible Party Name: (Last) _____ (First) _____ (MI) _____

Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female Phone # _____

Mailing Address _____ City, State, ZIP _____

Patient Relationship to Responsible Party _____

INSURANCE INFORMATION

Insurance Company _____ Their Phone # _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Person Code _____ Group ID _____

Insured Date of Birth _____ Insured's Social Security Number _____

PHARMACY INFORMATION

Pharmacy Name _____ Their Phone # _____

Address _____ City; State; Zip _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

IMPORTANT

Have you had any recent labs/blood work, imaging, primary care doctors visits, specialist doctors visits, etc?

List which facility/doctor you went to for each AND what you had done: _____

_____

_____

Name: _____ **Height:** _____ ft _____ in **Weight:** _____ lbs

List the name, dosage, and frequency of the medications you are currently taking: ☐ I don't take any medications

Current Medications	Dosage	Frequency

Please provide your PAST MEDICAL HISTORY:

- ☐ Allergies
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (enlarged prostate)
- ☐ Blood clots
- ☐ Cancer, Type ____
- ☐ CVA (stroke)
- ☐ COPD (emphysema)
- ☐ CAD (heart disease)
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes, type_____
- ☐ Gallbladder disease
- ☐ GERD (reflux)
- ☐ Hepatitis C
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Irritable bowel syndrome
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ MI (heart attack)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ AIDS/HIV

Other past medical history:_____

_____

Do you have any allergies? If so, list below: ☐ No Known Drug Allergies

Allergy	Reaction or Side Effect

Please tell us about any SURGERIES you have had, and indicate the DATE/YEAR if known: ☐ None (never had any surgeries)

- ☐ Angioplasty
- ☐ Colostomy
- ☐ Appendix
- ☐ Arthroscopy knee
- ☐ Back surgery
- ☐ CABG (open heart surgery)
- ☐ Carpal tunnel release
- ☐ Cataract
- ☐ Cholecystectomy (gallbladder)
- ☐ Eartube/BMT
- ☐ Colectomy (colon removed)
- ☐ Small bowel resection
- ☐ Gastric bypass
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ LASIK
- ☐ Liver biopsy
- ☐ Mastoidectomy
- ☐ Pacemaker
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tympanoplasty

Gender Specific Male:

- ☐ Prostatectomy
- ☐ TURP
- ☐ Vasectomy

Gender Specific Female:

- ☐ Breast augmentation
- ☐ Bilateral tubal ligation
- ☐ Breast biopsy
- ☐ Cesarean section
- ☐ D & C
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Breast reduction

Other past surgical history:_____

Past Hospitalizations unrelated to surgery: _____

Please provide your FAMILY HISTORY: (circle your answer)

Father:	☐ Alive	☐ Deceased	☐ Unknown	Medical History: _____
Mother:	☐ Alive	☐ Deceased	☐ Unknown	Medical History: _____
Paternal Grand Father:	☐ Alive	☐ Deceased	☐ Unknown	Medical History: _____
Paternal Grand Mother:	☐ Alive	☐ Deceased	☐ Unknown	Medical History: _____
Maternal Grand Father:	☐ Alive	☐ Deceased	☐ Unknown	Medical History: _____
Maternal Grand Mother:	☐ Alive	☐ Deceased	☐ Unknown	Medical History: _____

Do you have any siblings? _____ brother(s) _____ sister(s)

Do you have any children? _____ son(s) _____ daughter(s)

Please provide your SOCIAL HISTORY:

Smoking status:

☐ current cigarette smoker — If you're a current smoker, when did you start_____/_____/_____

How many cigarettes a day do you smoke? _____

Are you interested in quitting? ☐ Yes ☐ Maybe ☐ No

☐ former cigarette smoker — If you're a former smoker, when did you start? _____/_____/_____

And when did you stop smoking?....._____/_____/_____

☐ never smoked cigarettes

Do you drink alcohol?

☐ No
☐ Socially
☐ Daily

Who do you live with?

☐ Alone
☐ Spouse
☐ Significant Other
☐ Family
☐ Friends
☐ Other

Occupation?

☐ Work full-time
☐ Work part-time
☐ Self-employed
☐ Retired
☐ Unemployed
☐ Other

Highest education completed:

☐ 6th grade
☐ 7th grade
☐ 8th grade
☐ Bachelors
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ Masters
☐ Middle School
☐ High School
☐ Associates
☐ Other_____

Do you have any pets?

☐ cats/kittens
☐ dogs/puppies
☐ birds
☐ rabbits
☐ guinea pigs
☐ reptiles
☐ fish
☐ other

****

REVIEW OF SYMPTOMS: *Are you **currently** experiencing any of the following?*

Constitutional
☐ Fatigue
☐ Fever
☐ Night Sweats
☐ Weight loss

Cardiovascular
☐ Chest pain
☐ Irregular heartbeat
☐ Shortness of breath
☐ Swollen ankles

Ears/Nose/Throat
☐ Dizziness
☐ Hearing loss
☐ Ringing in ears
☐ Change in vision

Musculoskeletal
☐ Back pain
☐ Joint pain
☐ Muscle aches
☐ Stiffness

Respiratory
☐ Cough
☐ Trouble breathing
☐ Wheezing
☐ Sleep apnea

Neurologic
☐ Balance problems
☐ Headaches
☐ Numbness
☐ Seizures

Skin & Breast
☐ Hair loss
☐ Rash
☐ Skin lesions
☐ Pain in breast(s)

Genitourinary
☐ Genital discharge
☐ Frequent urination
☐ Excessive hunger
☐ Painful urination

Psychiatric
☐ Anxiety
☐ Depression
☐ Irritability
☐ Insomnia

Hem/Lymph
☐ Anemia
☐ Bruising easily

Authorization to Treat and Acknowledgement of Financial Responsibility

I understand that this authorization includes my consent for medical tests, procedures, drugs and other services and supplies as considered advisable. This treatment may include, but is not necessarily limited to, anesthesia, pathology, radiology and other imaging and diagnostic services, and other special tests and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of my examination, care, or treatment. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care.

I request that payment authorized by my insurance company, the Center for Medicare and Medicaid Services, or its carriers, be made on my behalf for services provided. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that it is my responsibility to notify the practice of any changes in my coverage. I understand that I am financially responsible for payment of services provided during this visit if I do not have insurance coverage or if I have coverage and timely payment is not made. I also understand that if I have a co-payment for this service, co-insurance, high deductible, or any appointment fee, it is payable on the date of service. I may be charged an additional fee to cover the cost of billing the co-payment, if not paid today. I understand that I am responsible for paying the amount of any discount imposed by my insurance provider or third party payer imposed discounts.

Some insurance companies require pre-authorization services. If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals, or other healthcare providers in connection with, or as a result of this visit, those charges may also be my responsibility, unless pre authorized as required by my insurance company.

I authorize the release of medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers as necessary to determine payment for these or related services.

Certain lab tests may be sent to an independent lab for processing. I understand that I may receive a separate bill for these services.

In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provision applies equally to myself or any individual for whom I am authorizing treatment.

Notice of Privacy Practices Acknowledgement

In general, the HIPAA Privacy Rule (Health Insurance Portability and Accountability Act of 1996 – Federal Law) gives individuals the right to request a restriction of uses and disclosures of their Protected Health Information (PHI). It also provides the right to request confidential communications between an individual and his/her physician's office.

To protect your privacy and in keeping with the Federal Privacy Law, all of your medical information, PHI, is kept strictly confidential. We will use this PHI for treatment, payment, and operations (TPO) of our medical practice. We will be required to get an authorization in writing from you if we intend to use your PHI for any other purpose.

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By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of our facility, give **Authorization to Treat**, and acknowledge your **Financial Responsibility**. Our notice of Privacy Practices is subject to change.

Printed Name: _____ Today's Date: _____/_____/_____

Signature: _____ (Patient / Parent / Legal Guardian

Authorizations

Read and initial

_____ I consent that Som Medical Practice PLLC can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of online communications, provided that these communications comply with privacy regulations.

_____ I understand that Som Medical Practice PLLC can reach me at any time to remind me of my appointments or let me know in case of any change about my appointments. And I also understand that Som Medical Practice PLLC can employ and use a third-party automated system to reach out to me for the purpose of "confirm", "reschedule" or "cancel".

_____ For telemedicine, I understand the appointments will be held via electronic environments.

_____ I accept that I am responsible for notifying Som Medical Practice PLLC when my contact information changes.

_____ I know that I can revoke this consent at any time by contacting Som Medical Practice PLLC.

_____ I consent to the use of mobile phone communications.

_____ I consent to the use of texting (messages) communications.

_____ I consent to receive electronic notifications for confirming, rescheduling or cancelling my appointments.

_____ I understand that if I fail to show for my scheduled appointment or do not notify the office of cancellation within 24 hours of my scheduled appointment time, I shall be subject to a $30 “No Show/Cancellation” fee. This fee is not covered by insurance and is therefore my sole responsibility to pay.

_____ I understand that if I need to cancel or reschedule my appointment, I have to call the clinic. If I have a problem getting through, I will leave a detailed message with my name, appointment date, and cancellation reason or request for rescheduling. I also understand that if I no show (3) times, I will no longer be permitted to schedule appointments.

_____ I understand that If I arrive more than 15 minutes late for my appointment, I will either have to wait until there is an open slot to be seen, or be rescheduled for a later date. This process will ensure patients that do arrive on time are seen in a timely manner.

We have exciting news regarding your health care!

As we continue in our efforts to provide you, our patients, with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of but also involved in the maintenance and improvement of your health.

To that end, we are proud to announce that our practice now offers you the opportunity to use the power of the web to track all aspects of your health care through our office. The Patient Portal enables our patients to communicate with our practice easily, safely, and securely over the Internet.

The Portal is a secure and convenient place to manage your health records and those of your family members as well.

Here are just some of the many features that think you will find useful.

Medical History

View your medical history (and that of family members). Medical History includes your Problem List, Allergies, Immunization Record, Lab/imaging/procedure results, and Medication List.

Appointments

Schedule, reschedule, or cancel appointments online. Receive appointment confirmation/reminder notifications.

Request Refills from your doctor

Request refills of authorized medications before you run out. Improved compliance means improved health outcomes.

Lab Reports

View the results of labs, imaging studies, and procedures once your healthcare provider has reviewed them.

Begin today to take an active role in managing your health care! **Print your Email Address below** to be added to the patient portal. You will receive a welcome email and instructions on how to access the portal.

Email Address: _____

Part I.

I, _____,
(name)
hereby appoint: _____ as my health care agent.
_____
(name, home address and telephone number of agent)

In the event that the person I name above is unable, unwilling, or reasonably unavailable to act as my agent, I

hereby appoint: _____ as my health care agent.
_____
(name, home address and telephone number of agent)

This health care proxy shall take effect in the event I become unable to make my own health care decisions. My agent has the authority to make any and all health care decisions for me, except to the extent that I state otherwise here:

_____
_____
_____

Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

_____
_____

When making health-care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

My agent should also consider the following instructions when making health care decisions for me:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Part II.

This Living Will has been prepared to conform to the law in the State of New York, and is intended to be "clear and convincing" evidence of my wishes regarding the health care decisions I have indicated below.

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to regarding health care under the circumstances indicated below:

LIFE-SUSTAINING TREATMENTS

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Choice 1 OR Choice 2)

Choice 1. ☐ The Choice **NOT** To Prolong Life

I do not want my life to be prolonged if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes. While I understand that I am not legally required to be specific about future treatments if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:

- ☐ I do not want cardiac resuscitation.
- ☐ I do not want mechanical respiration.
- ☐ I do not want artificial nutrition and hydration.
- ☐ I do not want antibiotics.

OR

Choice 2. ☐ The Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

_____

_____

OTHER WISHES:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

_____

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.
My agent, if I have appointed one in Part I or elsewhere, has full authority to resolve any question regarding my health care decisions, as recorded in this document or otherwise, and what my choices may be.

OPTIONAL ORGAN DONATION:

Upon my death: (choose only one applicable box)

Option 1. ☐ I **do not** give any of my organs, tissues, or parts and do not want my agent, guardian, or family to make a donation on my behalf;

Option 2. ☐ I give **any needed** organs, tissues, or parts;

OR

Option 3. ☐ I give **the following** organs, tissues, or parts only: _____
_____

My gift, if I have made one, is for the following purposes (strike out any of the following you **do not** want):

1. Transplant
2. Therapy
3. Research
4. Education

Part III.

Signed _____ Date _____

Print Name _____

Address _____

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Signed _____ Date_____

Print Name _____

Address _____

Witness 2

Signed _____ Date_____

Print Name _____

Address _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date 08/17/2021 Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Niagara Primary Care | Niagara Falls Urgent Care | Emerald Way Medical | Lockport Primary Care FAX: 716-215-6170

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**