

Scarsdale Medical Group
Bring to Billing Department after completing

First Name _____ MI _____ Last Name _____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Emergency Phone _____ Cell Phone _____
Fax _____ E-mail _____
Date of Birth _____ Sex _____ Marital Status _____ SSN _____
Appt Doctor _____ Referring Doctor _____

Insurance Information

Name of Primary Insurance Company _____
Address _____
Group # _____ Policy # _____
Subscriber Name _____
Relationship to Subscriber _____ Subscriber Date of Birth _____
Subscriber Employer Name _____
Employer Address _____
Employer Phone _____ Employer Fax _____

Name of Secondary Insurance Company _____
Address _____
Group # _____ Policy # _____
Subscriber Name _____
Relationship to Subscriber _____ Subscriber Date of Birth _____
Subscriber Employer Name _____
Employer Address _____
Employer Phone _____ Employer Fax _____

Employer Information of Patient if different from subscriber:

Employer Name _____
Employer Address _____
Employer Phone _____ Employer Fax _____

Insurance Authorization: I hereby authorize Scarsdale Medical Group to furnish information to insurance carriers concerning my illness and treatment and to receive payment on my behalf if the Scarsdale Medical Group agrees to accept assignment.

Patient Signature

Bring to Billing Department after completing

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

New York State Department of Health

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

- I consent to disclosure of (please check all that apply):
- My HIV-related information
 - Both (non-HIV medical and HIV-related information)
 - My non-HIV medical information **

Information in the box below must be completed.

<p>Name and address of facility/person disclosing HIV-related and/or medical information:</p> <p>_____</p> <p>_____</p>
<p>Name of person whose information will be released: _____</p>
<p>Name and address of person signing this form (if other than above):</p> <p>_____</p> <p>_____</p>
<p>Relationship to person whose information will be released: _____</p> <p>_____</p>
<p>Describe information to be released: _____</p>
<p>Reason for release of information: _____</p>
<p>Time Period During Which Release of Information is Authorized From: _____ To: _____</p>
<p>Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:</p> <p>_____</p> <p>_____</p>
<p>Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):</p> <p>_____</p> <p>_____</p>

<p>All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.</p> <p>Signature _____ Date _____</p>

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

**Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. Blank lines may be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature _____ Date _____

Client/Patient Number _____