Rockland Pulmonary & Medical Associates

Bon Secours Medical Group

A Member of the Westchester Medical Center Health Network

PATIENT INFORMATION

SS#: ______________________ DOB: ______________ MARITAL STATUS: **S M D W OTHER**

NAME: ____
FIRST MIDDLE LAST

ADDRESS: ____

____
CITY STATE ZIP CODE

HOME PHONE: ______________________ MOBILE PHONE: ______________________

RACE ETHNICITY ________________ PREFERRED LANGUAGE: ____________ RELIGION: ____________

EMAIL ADDRESS: ______________________ EMPLOYMENT STATUS: **UNEMPLOYED RETIRED FULL TIME PART-TIME STUDENT**

EMPLOYER NAME: ______________________ EMPLOYER PHONE: ______________________

GUARANTOR INFORMATION

NAME: ______________________ RELATIONSHIP TO PATIENT: ____________DOB: ____________

ADDRESS: ____

EMERGENCY CONTACT

NAME: ______________________

REL. TO PATIENT: ______________________

PHONE NO: ______________________

PRIMARY DOCTOR

NAME: ______________________

LOCATION: ______________________

PHONE: ______________________

REFERRING PHYSICIAN: ______________________

COVERAGE INFORMATION

WORKERS COMP/NO FAULT: **Is this visit under Workers Comp/ No Fault?** YES _______ NO________ CLAIM NUMBER: ______________________

INSURANCE INFORMATION

PRIMARY INS: ______________________ INS ID: ______________________

SUBSCRIBER NAME: ______________________ DOB: ____________ REL TO PATIENT: ____________

SUBSCRIBER SS#: ______________________ EMPLOYMENT OF SUBSCRIBER: **FULL TIME PART TIME SELF RETIRED**

MRN: ____

PATIENT NAME: ____ DOB: ___________________
(PLEASE PRINT)

ALLERGIES TO MEDICATION:

☐ **NOT TAKING ANY MEDICATIONS**

Pharmacy: _________________________________ Tel. ________________________________

MEDICATION	STRENGTH	HOW OFTEN

2 Crosfield Avenue Suite 318 West Nyack, NY 10994
257 Lafayette Avenue, Suite 340 Suffern, NY 10901
Tel: (845) 353-5600 Fax: (804) 261-4904
27 Liberty Square Mall, Stony Point NY 10980 Tel 845-942-4222 Fax 845-942-4223

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification 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. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. 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 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
Bon Secours Charity Health System Medical Group, PC - RPMA
2 Crosfield Avenue Suite 318 West Nyack, NY 10994

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: ______________ until ______________
INSERT START DATE — INSERT EXPIRATION DATE OR EVENT

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

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

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

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Health Maintenance Checklist

TEST	DATE	PLACE/DOCTOR
Mammogram Women 40yo and older annual		
Colonoscopy Age 50, repeat interval per GI specialist		
Bone Density Women age 65yo Repeat interval determined by doctor		
Pap smear Women 21-65yo every 3 years (or interval per GYN)		
Eye Exam Diabetics annual Glaucoma screen		
Recent Immunizations Flu/pneumonia/zoster		
Living Will or Advanced Directive		**If you have one please bring a copy to your visit**

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List of Physicians and consultants whom you are seeing

Consultant	Name (s)
Cardiology (heart)	
Pulmonary (Lungs)	
Gastroenterology (stomach)	
Nephrology (kidneys)	
Neurology (brain)	
Endocrinology (diabetes/thyroid)	
Oncology (Cancer)	
GYN (female)	
Urology (prostate/urinary)	
Dermatology (skin)	
ENT (ears,nose,throat,allergy)	
Surgeon	
Ophthalmology/Optometry (Eye doctor)	
Podiatry (Foot)	
Other:______________	