NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Patient Information Form

Last/Family Name:	**First:**	**Middle:**
Title: ☐ Mr. ☐ Mrs ☐ Ms. ☐ Miss.	**Age:**	**Date of Birth (Month/Day/Year):**
Primary Language:	**Patient Gender:** ☐ Male ☐ Female	**Have you previously been a patient?** ☐ Yes ☐ No
Will you be the sole person seeking treatment? (If No, please provide names of other patients) ☐ Yes ☐ No		
Address of Permanent Residence:		**Country:**
City:	**State/Province:**	**Postal Code:**
Home Phone:	**Mobile:**	**Email:**
Mother's Name:	**Father's Name:**	**Fax:**
Referring Physician:	**Phone:**	**Physician Email:**
Travel Dates/Length of Stay in New York:	**Have you obtained a Visa?** ☐ Yes ☐ No	**How did you learn about us?** ☐ Physician ☐ Family/Friend ☐ Government ☐ Insurance ☐ NYP Physician ☐ Print/TV/Radio ☐ Internet ☐ NYP Reputation
Diagnosis and or Requested Treatment:		
Method of Payment (If you have insurance, please provide details below):		
Insurance Name:	**Subscriber's name:**	**Group no.:**
Policy no.:	**Insurance Address:**	
Insurance Phone:	**Fax:**	**Insurance Email:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize NewYork-Presbyterian Hospital International Services or insurance company to release any information required to process my claims. By providing e-mail addresses, I allow correspondences regarding care to be communicated via email.

Patient/Guardian Signature:	**Date:**

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45350

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

An additional authorization (NYS DOH-2557) is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

Patient Name: _____

Patient Address: _____ _____ _____
City State Zip Code

Patient Date of Birth: _____/_____/_____ **Phone #:** (_____) _____

Medical Record Number: _____ **Maiden or Other Name** _____

I hereby authorize (check center) or other Healthcare Provider (specify):
☐ Columbia University Medical Center ☐ Weill Cornell Medical Center ☐ Westchester Division ☐ Other _____

To release (check one) ☐ **Protected Health Information and/or** ☐ **Sensitive Protected Health Information (see reverse side for definitions) pertaining to my:**
☐ Hospital admission **(date)** _____/_____/_____ ☐ Outpatient visit **(date)** _____/_____/_____
☐ Emergency Department visit **(date)** _____/_____/_____ ☐ Ambulatory/Outpatient admission **(date)** _____/_____/_____

I authorize disclosure of the following information from my medical record (check where applicable list type and date):
☐ Immunization _____ ☐ Lab Reports _____ ☐ Radiology and imaging reports _____
☐ Discharge Summary _____ ☐ Clinical Documentation _____ ☐ Pathology Reports _____
☐ Other **(describe)** _____

From my medical records to:
Name of organization or person: New York-Presbyterian/Columbia International Services
Address: 177 Fort Washington Ave, MHB-9 Central Apt. # _____
City New York State NY Zip Code 10032
Telephone (Area Code and Number): 1-212-305-4900

The purpose(s) for which disclosure is authorized (check where applicable):
☐ Medical Care ☐ Insurance ☐ Immunization ☐ Other **(specify)** _____

I understand that:

1. Treatment and payment will not be conditional on whether I provide Authorization for any requested disclosure by NewYork-Presbyterian Hospital.
2. **I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee.**
3. This Authorization is voluntary and that I have the right to refuse to sign it.
4. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practice; however such revocation would not affect any action taken by NYPH in reliance on this Authorization before receipt of my written revocation.
5. **This Authorization will expire on _____/_____/_____ (fill in date if less than 1 year) or 1 year after being signed.**
6. The information disclosed pursuant to this Authorization, ***except*** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
7. My medical records may contain genetic testing information including test results.
8. **This authorization is also applicable to patients with drug or alcohol related diagnoses, protected by Title 42 of the Code of Federal Regulations. (see reverse side for description)**

_____ _____/_____/_____
Signature of patient/personal representative (e.g., legal guardian) Date

_____
If personal representative, relationship to patient, print name

_____
Witness or Notary (This Authorization must be notarized if information is being released to an attorney and/or court.)

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