CRYSTAL RAY MEDICAL, P.C

96-14 63RD Drive

Rego Park, NY 11374

Tel (718) 896-0111 Fax (718) 896-2163

CASH/PRVT FORM

Today's Date:__________________
Fecha

Date of Birth: _________________
fecha del naciemiento

Name:______________________________
Nombre

Sex: ___M ____F

Address: ____________________________
____
____

Social Security: ____________________
numero de seguro social

Tel: (H) _______________(W)______________(Cell) _______________Phone Carrier:___________________

In case of an emergency who should we contact? Name:___________________Phone:__________________
En caso de una emergencia quien debemos contactar? Nombre: Telefono:

Name and address of Primary Doctor:____
Nombre y direction de Doctor Primario

INSURANCE INFORMATION: INFORMACION DE SEGURO:

Name and Address of the Health Insurance: ____
Is your name under your insurance: Yes/ No WHO: ____

Was this a Work/ Auto injury: If yes Please describe accident:
El acidente es relaccionado con el trabajo o carro : describa el acidente
____
____

Did you go to the Hospital: Fue usted al hospital? NO/YES__________________________________
____

What type of treatment did you receive in the Hospital: Que tratamiento recebio en el hospital?
____
____

Have you been treated in another office for this condition? Fue tratado por otra oficina para esta condicion: NO/ YES ____

What type of medication are you taking: Que medicina esta usando?______________________________
____

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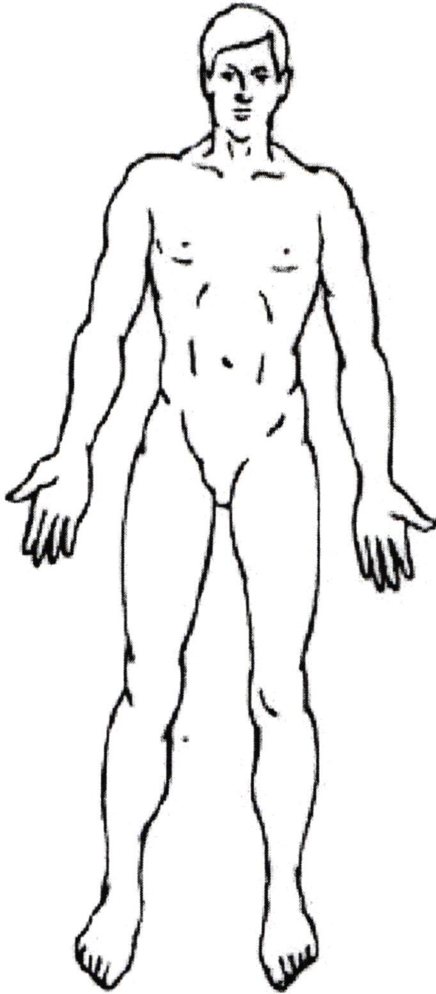
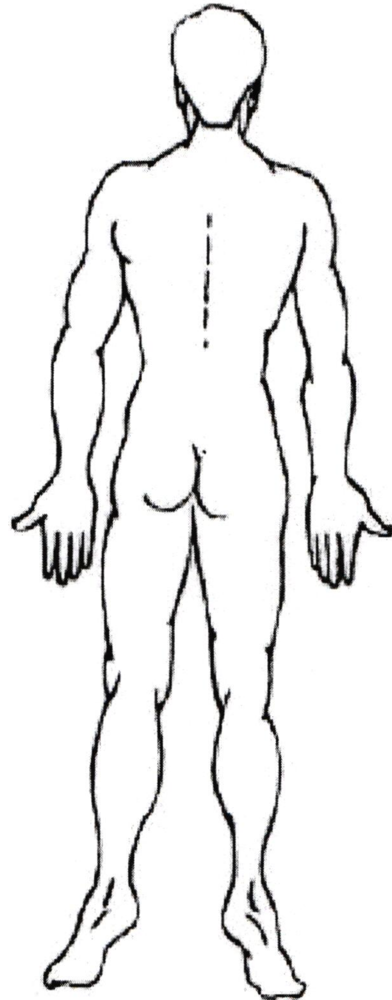
PLEASE, PLACE AN X ON THE BODY WERE YOU HAVE PAIN?





PATIENT SIGNATURE ______________________

DATE ______________________

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:

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.**

Crystal Ray Medical, PC

96-14 63rd Drive 2FL
Rego Park NY 11374
T: 718-896-0111 F: 718-896-2163

NOTICE OF PRIVACY PRACTICE

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

TREATMENT
Your health information may be used by staff member or disclosed to other health care professional for purpose of evaluation your health, diagnosing medical conditions and providing treatments. For example, results of laboratory test and procedures will be available in your medical records to all health professionals who may provide treatments or who may be consulted by staff members.

PAYMENTS
Your health information may be used to seek payment from health plans, from other source of coverage such as automobile insurer, or form credit care companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided and the medical conditions being treated.

LAW ENFORCEMENT
Your health information may be disclosed to law enforcement agencies to support government audits and inspections to facilities law enforcement investigations and to comply with government-mandated reporting.

PUBLIC HEALTH REPORTING
Your health information may be disclosed to public health agencies required to report certain communicable diseases to the state's public health department.

NOTICE OF PRIVATE PRACTICES
We care about our patient's privacy and strive to protect the confidentiality of your medical information at this facility. New Federal Legislation requires that we issue this official notice of our privacy practices. You may have the right to the confidentiality of your medical information and this practice is requiring by law to maintain the privacy of that information.

WHO WILL FOLLOW THIS NOTICE?
Any Health care Professional authorized to enter information into your medical records, all employees, staff and other personnel at this practice who may need access to your information must be abide by this notice. All subsidiaries, business associates (billing services) sites, and locations of this practice may share medical information with other for treatment, payment purpose or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task is shared.

____________________________ ______________________

Patient's Signature Date