PLEASE FILL OUT ALL INFORMATION!

Sarita Dhuper, MD **Pediatric Cardiology**

(If you are over 18 you may sign this form)

Name: _____ **Date of birth:** _____ **SEX:** _____

Address: _____ **Apt no:** _____ **City**_____ **State:** _____ **Zip** _____

Home Phone: _____ **Cell Phone:** _____ (Parent)_____

Social Sec. #– If over 18____-___-_____ **under 18- parents'**___-____-_____

Mother or Guardian name: _____ DOB:_____
Father or Guardian's name: _____ DOB:_____
Email Address:_____

Insurance: _____ **ID:** _____

For employer insurance only, *GHI, BC BS, etc*

Insured's Name: _____ Work Phone: _____
Date of birth of Insured: _____ **Soc. Sec. of insured:** _____
Employer: _____
Phone No: _____

Do you have other insurance? Yes or no ___ Name of Ins. Co: _____
Name of Insured_____ ID: _____ DOB:_____
Soc. Sec.: _____ Tel of Ins. Co.: _____
Employer: _____

Pediatrician or Referring Doctor _____
Address: _____
_____ Tel No.: _____

If this is a foster child do you have your ID and authorization for care? _____
Name of agency? _____

I hereby verify that all information given above is true and to the best of my knowledge. I hereby permit Dr. Dhuper to forward information to pediatrician/referring physician or to other provider of related services, on my behalf.

I understand that I am responsible for obtaining all referrals, co-payments and/or all payments for services rendered. I also understand that medical information may be used to obtain payment for services rendered.

_____ _____
Signature of Patient/Parent/Guardian Date

FOR OFFICE USE ONLY: (DO NOT WRITE BELOW THIS LINE)
Referral needed: ☐ Y ☐ N - Ref. No_____ Visits: _____Co.-Pay: _____
Verified? _____ Eff. date: _____ Primary: _____ Trace # _____
Comments:

PLEASE REMEMBER TO SIGN!

Revised 6/6/17

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(This remains a part of your chart)

SARITA DHUPER, MD – PEDIATRIC CARDIOLOGY/OBESITY

I herby give my consent for Sarita Dhuper, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO)

Sarita Dhuper, MD Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent; Sarita Dhuper MD reserves the right to revise its Notice of Privacy Practices at any time. A revised Noticed of Privacy Practices may be obtained by forwarding a written request to Sarita Dhuper, MD or assigned staff at 1162 Eastern Parkway, Brooklyn, NY 11213.

With this consent Sarita Dhuper, MD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO ,such appointment reminders, insurance items and may calls pertaining to my clinical care, other that of my minor child, laboratory results among others.

With this consent Sarita Dhuper, MD may email to my home or other alternative location any items that assist the practiced of carrying out TPO, such as appointment reminders and patience statements, as long as they are marked Personal And Confidential,

With this consent Sarita Dhuper, MD may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements, I have the right to request that Sarita Dhuper, MD restrict how her practice uses or discloses my PHI to carry out TPO.

The practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Sarita Dhuper MD's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If I do not sign this consent, or later revoke it, Sarita Dhuper, MD may decline to provide treatment to me

With this consent I understand that I may obtain information by contracting Sarita Dhuper, MD or her assigned staff at (718) 221-0333 or 718-221-1598. .

_____ _____

Signature of Patient (18+) or Legal Guardian/Parent **PRINT NAME**

_____ _____

Patient Name **Date Signed**

Please note that the exceptions to the above are to be made:

_____

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 _____ (Initials) I authorize _____ (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.**