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:

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: _____ (INSERT START DATE) until _____ (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.

Dr. Neil Paulvin

Board Certified in Integrative Medicine, Anti-Aging, Family Medicine and Osteopathic Manipulation

Patient Information

Patient Name: _____
Last First Middle

Patient Address: _____ *Apt. #:* _____

City: _____ *State:* _____ *Zip Code:* _____

Home Phone: _____ *Cell Phone:* _____

Employer: _____ *Work Phone:* _____

Social Security Number: _____ *E-Mail:* _____

Date of Birth: _____ *Place of Birth:* _____

Emergency Contact: _____ *Emergency Phone:* _____

Primary Health Insurance Company: _____

Policy Holder: _____ *Insured Name (if different):* _____

Insured Person ID #: _____ *Insured Person SSN:* _____

Insured Employer: _____ *Insured Date of Birth:* _____

Group Number: _____ *Group Name:* _____

Secondary Health Insurance Company: _____

Policy Holder: _____ *Insured Name (if different):* _____

Insured Person ID #: _____ *Insured Person SSN:* _____

Third Health Insurance Company: _____

Policy Holder: _____ *Insured Name (if different):* _____

Insured Person ID #: _____ *Insured Person SSN:* _____

Referring Facility: _____ *Referring Physician:* _____

I, the undersigned person, hereby authorize the release of any information relating to my illness, treatments and claims for the benefits submitted on behalf of myself and/or my dependents. I further agree and acknowledge that my signature on this document authorized my doctor to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim submitted for myself and/or my dependents. I request that my health insurance benefits be assigned directly to Neil Paulvin, DO. If my health insurance company sends payment directly to me, I agree to remit all endorsed payment and explanation of benefits directly to Neil Paulvin, DO. I further understand I am financially responsible for all charges, whether or not paid by my health insurance carrier.

Name: _____ Signature: _____ Date: _____

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Health History

Welcome to the practice. As a new patient, please fill out the information found below to the best of your ability.

Name: _____ Birthdate: _____ Date: _____

Reason for visit: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Past Medical History

Have you ever had the following (Please write "yes" or "no")

_____ Measles
_____ Mumps
_____ Chickenpox
_____ Whipping Cough
_____ Scarlet Fever
_____ Diphtheria
_____ Smallpox
_____ Pneumonia
_____ Rheumatic Fever
_____ Heart Disease
_____ Arthritis
_____ Venereal Disease
_____ Anemia
_____ Bladder Infections
_____ Epilepsy
_____ Migraine Headaches
_____ Tuberculosis

_____ Diabetes
_____ Cancer
_____ Polio
_____ Glaucoma
_____ Hernia
_____ Blood Transfusion
_____ Back Trouble
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Hemorrhoids
_____ Date of last chest x-ray
_____ Asthma
_____ Hives or Eczema
_____ AIDS or HIV+
_____ Infectious Mono
_____ Bronchitis

_____ Mitral Valve Prolapse
_____ Stroke
_____ Hepatitis
_____ Ulcer

_____ Kidney Disease
_____ Thyroid Disease
_____ Bleeding Tendency
_____ Cold Sores
_____ Bells Palsy
_____ Keloid Scarring
_____ Poor Scar Healing
_____ Any Other Disease

_____
_____
_____

Previous Surgeries / Hospitalizations When Hospital, City, State

_____ _____
_____
_____ _____
_____
_____ _____
_____
_____ _____
_____

Medications (include non-prescription): _____
_____
_____
_____

Do you presently take any of the following Medications:

Coumadin or Warfarin _____
Aspirin _____
Vitamin E _____
Anti-inflammatory medications (i.e., Motrin, Advil) _____
Herbal medications _____

Have you ever taken the following medications:

Fen-Phen/Redux _____
Accutane _____

Have you ever seen a psychiatrist or therapist?

_____

Are you currently taking any psychiatric medications: _____

Social History

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco: Never: _____ Previously, but quit on: _____ Current (packs per day): _____
Use of Drugs: Never: _____ Type/frequency: _____

Family Medical History

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems

_____ Insomnia

Endocrine
_____ Glandular problem
_____ Hormonal problem
_____ Excessive thirst or urination
_____ Heat or cold intolerance
_____ Skin becoming dryer
_____ Change in hat or glove size

Hematology/lymphatic
_____ Slow to heal after cuts
_____ Easy bleeding or bruising
_____ Anemia
_____ Phlebitis
_____ Previous transfusion
_____ Enlarged gland

Allergic/Immunologic
History of skin reaction or other adverse reaction to:
_____Penicillin or other oral/intravenous antibiotics
_____Neosporin, Bacitracin/other topical antibiotics
_____Morphine, Demerol or other narcotic
_____Novocain or other anesthetics
_____Epinephrine (adrenaline)
_____Aspirin or other pain remedies
_____Iodine, merthiolate or other antiseptic
_____Latex
_____Adhesives or Band Aids
_____Anesthesia or anesthetic medications
_____Other drugs or medications
Please list others _____

For Women Only:
History of:
Yeast vaginitis related to antibiotics _____
Breast cancer personally _____
Breast cancer in your family _____
Are you:
Pregnant or nursing? _____
Planning a pregnancy? _____
Date of:
Last mammogram _____
Last menstrual period _____