The Internal Medicine Offices of
PAUL S. COHEN MD

Patient Consent and Release Form

YES	NO	
		CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my healthcare provider to examine and treat me. I understand that this could include lab tests, education, or other diagnostic procedures and treatment, and that I have the right to refuse the recommended treatment.
		ELECTRONIC PRESCRIBING: I authorize Paul S. Cohen MDPC to retrieve my medication history through their e-prescribing system and then import it into my electronic medical record.
		BILLING AUTHORIZATION: I hereby authorize Paul S. Cohen MDPC to release requested medical information to my insurance company to collect payment for any charges incurred.
		ASSIGNMENT OF BENEFITS: I hereby request that payment of insurance benefits be made directly to Paul S. Cohen MDPC on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relaing to the service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.
		PATIENTS' RIGHT TO PRIVACY: I acknowledge I have been made aware of Paul S. Cohen MDPC's privacy practices, which are posted in the reception area. If I would like a copy of the HIPAA notice, I will ask for one.
		I hereby authorize Paul S. Cohen MDPC to verbally communicate regarding my care with : **FAMILY MEMBER/CAREGIVER** _____ Name Relationship
		CONSENT TO CONTACT : By placing check mark in the appropriate box, I hereby give consent for Paul S. Cohen MDPC to contact me regarding **health information, appointments, billing and announcements** by ☐ EMAIL ☐ PHONE ☐ TEXT MESSAGE Email address_____
		CONSENT FOR TESTING : I consent to undergo drug and alcohol testing if the physician/provider believes it is medically indicated to do so before treating me with any medications. I understand the nature and consequences of being tested for such substances..

HEALTH INFO EXCHANGE: Health-e Connections ™ is a non-profit organization that shares information regarding patient's health electronically and securely. To learn more about ehealth in NewYork State visit website www.ehealth4ny.org.

☐ **I GIVE CONSENT** for Paul S. Cohen MDPC to access ALL of my electronic health information through Health-e Connections ™ in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT** for Paul S. Cohen MDPC to access my electronic health information through Health-e Connections ™ for any purpose, *even in a medical emergency. NOTE:* **Unless you check this box, New York State law allows the people treating you in an emergency to have access to your medical records, including records that are available through Health-e Connections ™.**

_____ Print Name of Patient

_____ Patient Date of Birth

_____ Signature of Patient or Patient's Legal Representative

_____ Patient Preferred Language

_____ Date