Hafeez U Rehman, MD

2510 Riverfront Center
Amsterdam, N.Y. 12010

Phone (518) 627-0469 Fax (518) 627-0467

Name_____ sex_____

Address_____
_____
Phone#_____Work #_____

Birth Date_____Social Security #_____

Spouse/Legal guardian_____

Address_____
_____
Phone #_____Work #_____
Birth Date_____Social Security #_____

Emergency contact_____Phone_____
Addres_____

Employer: _____Phone_____
Address:_____

Insurance carrier information/No fault/Workers comp.

Carrier name:_____ I.D.#_____
Primary holder_____
Secondary Insurance_____I.D.#_____
Injury no fault case #_____WC #_____
Pharmacy used_____

I hereby authorize Hafeez U Rehman, MD to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature_____Date_____
Parent Signature if patient is a minor_____

MEDICAL RELEASE FORM

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I _____DOB_____ Authorize_____
Patient (Previous Primary Care Physician)

To disclose to HAFEEZ U REHMAN, MD **the following information:** ALL MEDICAL RECORDS, NOTES, LAB.REPORTS, CT or OTHER REPORTS **for the purpose of** CONTINUED CARE.

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that information has already been released in reliance on the consent and that in any event, this consent expires automatically as directed below.

Specifications of the data, event, or conditions upon which this consent expires:
_____
_____

EXECUTED THIS_____DAY OF _____20_____

_____
Signature of Patient or Guardian

_____
Witness

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CRF Part 2) prohibits you from making any further disclosure of it without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations.

HAFEEZ U REHMAN, MD
Internal Medicine
518 627-0469

2510 Riverfront Center * Amsterdam, N.Y. 12010

NOTICE OF PRIVACY PRACTICE

I,_____,acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

_____
Signature

_____
Date

Hafeez U Rehman, MD

2510 Riverfront Center
Amsterdam, N.Y. 12010

Phone (518) 627-0469 **Fax (518) 627-0467**

Problem List

Medical Issue	Medications

WE GLADLY ACCEPT ALL MAJOR CREDIT CARDS

Hafeez Rehman,MD