BORIS A. KHAIMOV, D.O.
CHILD, ADOLESCENT & ADULT PSYCHIATRY
NYS License 249224
Tax I.D. 452574747

Patient Name: _____ Birth date: _____

Maiden or other name (if applicable) _____

I request and authorize Dr. Boris Khaimov to release / receive the health care information described below to / from:

Name: _____ at phone # _____
Address:
_____
City, State: _____ Zip code: _____

Please initial to specifically authorize the use and / or disclosure of:

Emergency Room/Urgent Care Records _____ Admission Note _____
Hospital Records (nursing and progress notes) _____ Discharge Summary _____
Initial Psychiatric Evaluation _____ Clinical Summary _____
Medication History _____
Outpatient Progress Notes _____ Psychological Test Report_____
Consultation Report (specify) _____
Laboratory Reports (specify) _____ X-ray Reports (specify) _____
Billing Statements _____ Verbal Discussion of Case_____
Other (specify) _____

The requested records or information is about health care provided during the following approximate time frame: **One Year**

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making written request to Dr. Boris Khaimov.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

Signature (patient or authorized representative) _____
Date: _____
Relationship/authority (if signed by authorized representative): _____
I have received a copy of this signed authorization: (please initial) _____ yes _____ no

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