NYC Health

CONFIDENTIAL

New York City A1C Registry: "Do Not Contact" Request

Please mail the completed form to:
Diabetes Prevention and Control Program
NYC Department of Health and Mental Hygiene
Gotham Center
42-09 28th Street, 12th Floor, CN-52
Queens, NY 11101-4132

If you do not want to be contacted, either by letter or by phone, regarding your A1C information and if you do not want your provider(s) to receive your A1C information from the NYC Department of Health and Mental Hygiene, please fill out this form.

By submitting this form, you are requesting that (1) you are not contacted about your A1C information and (2) that your provider(s) not get your A1C information through the Department's program. Submitting a "Do Not Contact" request will in no way affect the current care you are receiving or information your provider(s) receives from the laboratory directly. Please note that if your personal information (name, address, or phone number) changes in the future, you need to submit a new request not to be contacted.

You must complete these required fields or your request cannot be processed.

Please enter the name and address you give your provider's office.

First name _____ **Middle name (or initial)** _____

Last name _____

Date of birth (mm/dd/yyyy) _____

Street address _____ **Apt. number** _____

City _____ **State** _____ **Zip code** _____

Phone (optional) (_____) _____-_____

Signature _____

A letter to confirm your request will be sent within 30 days. If you do not receive this, you should contact the Diabetes Prevention and Control Program by calling 311.

If you are completing this form on behalf of someone else, please enter your name, state your relationship to the individual, and sign below.

First name _____ **Last name** _____

Relationship to patient (please check appropriate box)

☐ Legal guardian ☐ Parent of a minor (patient is under 18 years of age)

Signature _____

Rev. 4-9-13