

Important Request

Dear Patient:

We are required by the New York State Department of Health and the Office of Civil Rights of the United States Government to provide certain race and ethnicity information concerning all admissions to this facility.

We would greatly appreciate if you would choose the appropriate designations below so we may comply with this requirement. If you do not wish to provide this information, please check that box and sign your name. **Of course, compliance with this request for information is purely voluntary and will have no bearing upon your admission to the Hospital.**

Race (please check one):

- | | |
|---|---|
| <input type="checkbox"/> Black | <input type="checkbox"/> White |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> American Indian/Eskimo/Aleut |
| <input type="checkbox"/> All Other | <input type="checkbox"/> Unknown |

Ethnicity (please check one):

- | | |
|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Non Hispanic |
|-----------------------------------|---------------------------------------|

I do not wish to provide this information

Signature of Patient or Representative Date

Patient's Name

Medical Record Number

Date of Admission