



*New York State Board for Professional Medical Conduct*

433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Nirav R. Shah, M.D., M.P.H.  
Commissioner  
NYS Department of Health  
Keith W. Servis, Director  
Office of Professional Medical Conduct

Public

Kendrick A. Sears, M.D.  
Chair  
Carmella Torrelli  
Vice Chair  
Katherine A. Hawkins, M.D., J.D.  
Executive Secretary

February 18, 2011

***CERTIFIED MAIL-RETURN RECEIPT REQUESTED***

Firooz N. Tabrizi, M.D.  
2102 Genesee Street  
Utica, NY 13502

Re: License No. 105058

Dear Dr. Tabrizi:

Enclosed is a copy of BPMC #11-40 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect February 25, 2011.

Sincerely,

REDACTED

Katherine A. Hawkins, M.D., J.D.  
Executive Secretary  
Board for Professional Medical Conduct

Enclosure

cc: John T. Maloney, Esq.  
Carter, Conboy, Case, Blackmore,  
Maloney & Laird  
20 Corporate Woods Boulevard  
Albany, NY 12211-2362

**IN THE MATTER  
OF  
FIROOZ TABRIZI, M.D.**

CONSENT  
ORDER

BPMC No. #11-40

Upon the application of (Respondent) Firooz Tabrizi, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 2-18-2011

REDACTED

~~\_\_\_\_\_~~  
KENDRICK A. SEARS, M.D.  
Chair  
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH  
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER  
OF  
FIROOZ TABRIZI, M.D.

CONSENT  
AGREEMENT  
AND  
ORDER

Firooz Tabrizi, M.D., represents that all of the following statements are true:

That on or about October 16, 1969, I was licensed to practice as a physician in the State of New York, and issued License No. 105058 by the New York State Education Department.

My current address is 2102 Genesee Street, Utica, New York 13502, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct has charged me with twenty-six (26) specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit A, is attached to and part of this Consent Agreement.

I admit to the Twenty-First through Twenty-Eighth Specifications and the Factual Allegations contained therein, in full satisfaction of the charges against me, and I agree to the following penalty:

Immediately upon issuance of the Consent Order for which I apply, my license to practice medicine shall be limited, pursuant to N.Y. Pub. Health Law § 230-a, to preclude patient contact and any practice of medicine, clinical or otherwise. I shall be precluded from diagnosing, treating, operating, or prescribing for any human disease, pain, injury, deformity, or

physical condition. I shall be precluded from further reliance upon my license to practice medicine to exempt me from the licensure, certification or other requirements set forth in statute or regulation for the practice of any other profession licensed, regulated or certified by the Board of Regents, Department of Education, Department of Health or the Department of State.

I understand and I further agree that the Consent Order for which I apply shall be in full resolution of the Statement of Charges (Exhibit A), as well as the Office of Professional Medical Conduct's investigation of my care of the patient named in Appendix A-1.

I further agree that the Consent Order for which I apply shall impose the following conditions:

- That Respondent shall, within 30 days of the issuance of the Consent Order, notify the New York State Education Department, Division of Professional Licensing Services, that Respondent's license status is "inactive," and shall provide proof of such notification to the Director of OPMC immediately upon having done so; and
- That Respondent shall return any and all official New York State prescriptions to the Bureau of Narcotic Enforcement, and shall surrender Respondent's Controlled Substance Registration Certificate to the United States Department of Justice, Drug Enforcement Administration, within 15 days of the Order's effective date. All submissions to the DEA shall be addressed to Diversion Program Manager, New York Field Division, U.S. Drug Enforcement Agency, 99 Tenth Avenue, New York, NY 10011. Further, within 30 days of returning these prescriptions and surrendering the registration, Respondent shall provide documentary proof of these transaction(s) to the Director of OPMC; and
- That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This

condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State; and

- That Respondent shall comply with all conditions set forth in attached Exhibit B ("Requirements for Closing a Medical Practice").

I stipulate that my failure to comply with any conditions of this Order shall constitute misconduct as defined in N.Y. Educ. Law § 6530(29).

I agree that if I am charged with professional misconduct in the future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website.

I stipulate that the proposed sanction and Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board for Professional Medical Conduct and the Office of Professional Medical Conduct have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

I am aware and agree that, regardless of prior communication, the attorney for the Department, the Director of the Office of Professional Medical Conduct, and the Chairperson of the State Board for Professional Medical

Conduct each reserve full discretion to enter into the Consent Agreement that I propose in this application, or to decline to do so.

REDACTED

DATE 2/7/11

FIROOZ TABRIZI, M.D.  
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 2/8/11

REDACTED

JOHN MALONEY, ESQ.  
Attorney for Respondent

DATE: 2/10/11

REDACTED

CINDY M. FASCIA  
Associate Counsel  
Bureau of Professional Medical Conduct

DATE: 2/17/11

REDACTED

KEITH W. SERVIS  
Director  
Office of Professional Medical Conduct

IN THE MATTER  
OF  
FIROOZ TABRIZI, M.D.

STATEMENT  
OF  
CHARGES

FIROOZ TABRIZI, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 16, 1969, by the issuance of license number 105058 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. Respondent provided psychiatric care to Patient A on various occasions from approximately May 25, 2004 through April 14, 2005, at Respondent's office located at 2102 Genessee Street, Utica, New York ("Respondent's office") and at Faxton-St. Luke's Hospital in Utica, New York. Respondent's medical care of Patient A failed to meet the minimum accepted standard of care, in that:
1. Respondent failed to timely perform and/or timely document his inpatient assessment for Patient A's June 8, 2004 admission.
  2. Respondent failed to timely prescribe an anti-depressant for Patient A.
  3. Respondent failed to develop or consider an adequate differential diagnosis.
  4. Respondent discharged the patient one day after removing her from 15 minute checks.
  5. Respondent failed to address and/or to document any effort to address the patient's complaints about him and/or to adequately document the reason for Patient A's request for a change of

psychiatrist.

6. Respondent maintained separate/double entries for this patient in Respondent's office record and in the Faxton-St. Luke's hospital record.
  7. Respondent set a follow-up appointment for after the patient's discharge that was not timely, and/or failed to document any reason for said delay.
  8. Respondent failed to maintain a medical record which adequately documented his care and treatment of Patient A.
- B. Respondent provided psychiatric care to Patient B on various occasions from approximately March 26, 1998 through May 9, 2006 at Respondent's office and at Faxton-St. Luke's Hospital. Respondent's care of Patient B failed to meet the minimum accepted standard of care, in that:
1. Respondent inappropriately continued to prescribe benzodiazepines to Patient B.
  2. Respondent, despite incidents where Patient B overdosed on prescribed medications, continued with the same medication regimen and/or continued to prescribe substances prone to abuse.
  3. Respondent, despite incidents where Patient B claimed to have lost his prescribed medications, continued with the same medication regimen and/or continued to prescribe substances prone to abuse.
  4. Respondent failed to timely confront and/or failed to document timely confrontation of Patient B regarding the patient's drug abuse.
  5. Respondent failed to develop and/or document development of a clear plan to deal with Patient B's mental health and substance abuse

issues.

6. Respondent, when he did change Patient B's drug regimens, did so without sufficient documentation as to the reason for the change.

C. Respondent provided psychiatric care to Patient C on various occasions from approximately December 6, 2003 through February 2, 2004 at Respondent's office and at Faxton-St. Luke's Hospital. Respondent's care of Patient C failed to meet the minimum accepted standard of care, in that:

1. Respondent failed to timely perform and/or timely document his inpatient assessment for Patient C's December 6, 2003 admission.
2. Respondent maintained separate/double entries for this patient in Respondent's office record and in the Faxton-St. Luke's hospital record.
3. Respondent failed to document in his diagnosis of Patient C that the patient was exhibiting psychotic features.
4. Respondent failed to prescribe and/or to consider prescribing a mood stabilizer for Patient C, and/or failed to document his consideration of and reasoning for not prescribing a mood stabilizer.
5. Respondent failed to adequately evaluate Patient C prior to discharging her from the hospital on December 22, 2003 and/or prematurely discharged Patient C on December 22, 2003.
6. Respondent, after Patient C was readmitted to the hospital on December 26, 2003, failed to consider or document any consideration of reasons for Patient C's rapid decompensation after her discharge on December 22, 2003.

7. Respondent, during the patient's rehospitalization commencing on December 26, 2003, failed to develop or document a plan to address the reasons for Patient C's rapid decompensation.
  8. Respondent failed to maintain a medical record which adequately documented his treatment of Patient C.
- D. Respondent provided psychiatric care to Patient D on various occasions from approximately September 2, 2003 through September 2007 at Respondent's office and at Faxton-St. Luke's Hospital. Respondent's care of Patient D failed to meet the minimum accepted standard of care, in that:
1. Respondent failed to timely perform and/or timely document his inpatient assessment for Patient D's December 15, 2003 admission.
  2. Respondent, despite documenting psychotic symptoms, failed to timely prescribe an anti-psychotic for Patient D.
  3. Respondent failed to timely alter Patient D's medication regimen with regard to anti-psychotic medication, despite Patient D's failure to adequately respond.
  4. Respondent failed to adequately document the reasons for the plan to transfer Patient D to Mohawk Valley Psychiatric Center (MVPC).
  5. Respondent, after Patient D refused to sign discharge papers on or about December 29, 2003, inappropriately allowed Patient D to remain in the hospital on informal status.
  6. Respondent, following Patient D's refusal to sign discharge papers, failed to take adequate measures to develop a plan of action for Patient D.

7. Respondent, on March 8, 2004, the day of Patient D's discharge, decreased Patient D's medications.
  8. Respondent maintained separate/double entries for this patient in Respondent's office record and in the Faxton-St. Luke's Hospital record.
  9. Respondent failed to maintain a medical record which adequately documented his care and treatment of Patient D.
- E. Respondent provided psychiatric care to Patient E on various occasions from approximately June 19, 2004 through July 19, 2004, and again from approximately July 24 through August 15, 2004 at Faxton-St. Luke's Hospital. Respondent's care of Patient E failed to meet the minimum accepted standard of care, in that:
1. Respondent failed to timely perform and/or timely document his inpatient assessment for Patient E's June 19, 2004 admission.
  2. Respondent maintained separate/double entries for this patient in Respondent's office record and in the Faxton-St. Luke's Hospital record.
  3. Respondent, despite the presence of psychosis, failed to timely order a regimen of Seroquel that was in an effective anti-psychotic range.
  4. Respondent failed to adequately evaluate Patient E prior to discharging him from the hospital on July 19, 2004 and/or prematurely discharged Patient E on July 19, 2004.
  5. Respondent, after Patient E was readmitted to the hospital on July 24, 2004, failed to consider or document any consideration of reasons for Patient E's rapid decompensation after his discharge on July 19, 2004.

6. Respondent, after Patient E was placed in five point restraints on August 2, 2004 for attempting to assault staff, failed to increase Patient E's Seroquel dose for three days and/or still failed to increase Seroquel to a dose that was in an effective anti-psychotic range.
  7. Respondent failed to maintain a medical record for Patient E which adequately documented his care and treatment of Patient E.
- F. Respondent provided psychiatric care to Patient F on various occasions from approximately August 19, 2003 through August 26, 2004, at Respondent's office and at Faxton-St. Luke's Hospital. Respondent's medical care of Patient F failed to meet the minimum accepted standard of care, in that:
1. Respondent failed to timely perform and/or timely document his inpatient assessment for Patient F's January 15, 2004 admission.
  2. Respondent, after discontinuing Abilify, failed to prescribe a different anti-psychotic for Patient F and/or failed to document his rationale for failing to prescribe another anti-psychotic medication for Patient F.
  3. Respondent failed to document his reasoning for the difference between his discharge diagnosis of schizoaffective disorder on January 27, 2004 for Patient F and his April 30, 2004 diagnosis of bipolar affective disorder, unspecified.
  4. Respondent maintained separate/double entries for this patient in Respondent's office record and in the Faxton-St. Luke's Hospital record.
  5. Respondent failed to maintain a medical record which adequately documented his care and treatment of Patient F.

G. Respondent provided psychiatric care to Patient G on various occasions from approximately November 15, 2001 through November 21, 2007 at Respondent's office and at Faxton-St. Luke's Hospital. Respondent's medical care of Patient G failed to meet the minimum accepted standard of care, in that:

1. Respondent failed to timely perform and/or timely document his inpatient assessment for Patient G's admission of July 4, 2003.
2. Respondent failed to write an adequate initial note for Patient G's July 4, 2003 admission and/or failed to adequately document how the patient's cocaine abuse might relate to her presentation.
3. Respondent failed to adequately address Patient G's depression and/or failed to adjust her medication regimen until the day before he discharged Patient G.
4. Respondent failed to prescribe adequate anti-psychotic medication for Patient G and/or failed to document his reasoning for not prescribing same.
5. Respondent prematurely discharged Patient G and/or failed to adequately coordinate with substance abuse treatment providers prior to discharging Patient G.
6. Respondent maintained separate/double entries for this patient in Respondent's office record and in the Faxton-St. Luke's Hospital records.
7. Respondent failed to maintain a medical record which adequately documented his care and treatment of Patient G.

H. Respondent provided psychiatric care to Patient H on various occasions from approximately November 7, 2002 through February 4, 2004 at Respondent's office and at Faxton-St. Luke's Hospital. Respondent's medical care of Patient H failed to meet the minimum accepted standard of care, in that:

1. Respondent failed to timely perform and/or timely document his initial inpatient assessment for Patient H's January 17, 2003 admission.
2. Respondent, despite the fact that he documented a diagnosis for Patient H that states "without psychotic features", prescribed Trilafon, an anti-psychotic, for Patient H.
3. Respondent, despite Patient H's lack of response to or improvement from his medication regimen, failed to make any significant adjustment to said regimen.
4. Respondent considered ECT treatment for Patient H, and discussed ECT treatment with Patient H, without having exhausted other treatment modalities and/or without adequate attempts to adjust and/or supplement the patient's medication regimen.
5. Respondent failed to adequately adjust and/or consider Patient H's treatment needs while Patient H was awaiting transfer to Mohawk Valley Psychiatric Center.
6. Respondent maintained separate/double entries for this patient in Respondent's office record and in the Faxton-St. Luke's Hospital record.
7. Respondent failed to maintain a medical record which adequately documented his care and treatment of Patient H.

I. Respondent provided psychiatric care to Patient I on various occasions from approximately December 6, 2000 through May 2005 at Respondent's office and at Faxton-St. Luke's Hospital. Respondent's medical care of Patient I failed to meet the minimum accepted standard of care, in that:

1. Respondent failed to make an adequate on-service note in Patient I's inpatient record.
2. Respondent failed to consider or to document consideration that Patient I's presentation may have been due to cocaine abuse.
3. Respondent failed to consider or document a diagnosis of cocaine abuse and failed to develop and/or document a plan for substance abuse management for this patient.
4. Respondent maintained separate/double entries for this patient in Respondent's office record and in the St. Luke's hospital record.
5. Respondent failed to maintain a medical record which adequately documented his care and treatment of Patient I.

## **SPECIFICATION OF CHARGES**

### **FIRST THROUGH NINTH SPECIFICATIONS PRACTICING WITH GROSS NEGLIGENCE**

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges:

1. The facts of Paragraph A and any or all of the following subparagraphs: A.1, A.2, A.3, A.4, A.5, A.6, A.7 and/or A.8.
2. The facts of Paragraph B and any or all of the following subparagraphs: B.1, B.2, B.3, B.4, B.5 and/or B.6.
3. The facts of Paragraph C and any or all of the following subparagraphs: C.1, C.2, C.3, C.4, C.5, C.6, C.7 and/or C.8.
4. The facts of Paragraph D and any or all of the following subparagraphs: D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8 and/or D.9.
5. The facts of Paragraph E and any or all of the following subparagraphs: E.1, E.2, E.3, E.4, E.5, E.6 and/or E.7.
6. The facts of Paragraph F and any or all of the following subparagraphs: F.1, F.2, F.3, F.4 and/or F.5.
7. The facts of Paragraph G and any or all of the following subparagraphs: G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7.
8. The facts in Paragraph H and any or all of the following subparagraphs: H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.
9. The facts in Paragraph I and any or all of the following subparagraphs: I.1, I.2, I.3, I.4 and/or I.5.

**TENTH THROUGH EIGHTEENTH SPECIFICATIONS**  
**PRACTICING WITH GROSS INCOMPETENCE**

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(6) by practicing the profession of medicine with gross incompetence, in that Petitioner charges:

10. The facts of Paragraph A and any or all of the following subparagraphs: A.1, A.2, A.3, A.4, A.5, A.6, A.7 and/or A.8.
11. The facts of Paragraph B and any or all of the following subparagraphs: B.1, B.2, B.3, B.4, B.5 and/or B.6.
12. The facts of Paragraph C and any or all of the following subparagraphs: C.1, C.2, C.3, C.4, C.5, C.6, C.7, and/or C.8.
13. The facts of Paragraph D and any or all of the following subparagraphs: D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8 and/or D.9.
14. The facts of Paragraph E and any or all of the following subparagraphs: E.1, E.2, E.3, E.4, E.5, E.6 and/or E.7.
15. The facts of Paragraph F and any or all of the following subparagraphs: F.1, F.2, F.3, F.4 and/or F.5.
16. The facts of Paragraph G and any or all of the following subparagraphs: G.1, G.2, G.3, G.4, G.5, G.6 and/or G.7.
17. The facts in Paragraph H and any or all of the following subparagraphs: H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.
18. The facts in Paragraph I and any or all of the following subparagraphs: I.1, I.2, I.3, I.4 and/or I.5.

## **NINETEENTH SPECIFICATION**

### **PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

19. The facts of Paragraphs A, B, C, D, E, F, G, H and/or I, and any or all subparagraphs.

## **TWENTIETH SPECIFICATION**

### **PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

20. The facts of Paragraphs A, B, C, D, E, F, G, H and/or I, and any or all subparagraphs.

## **TWENTY-FIRST THROUGH TWENTY-EIGHTH SPECIFICATIONS**

### **FAILURE TO MAINTAIN ACCURATE RECORDS**

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

21. The facts in Paragraph A and A.8.
22. The facts in Paragraph C and C.8.
23. The facts in Paragraph D and D.9.
24. The facts in Paragraph E and E.7.
25. The facts in Paragraph F and F.5.
26. The facts in Paragraph G and G.7.
27. The facts in Paragraph H and H.7.
28. The facts in Paragraph I and I.5.

DATE: January 18, 2011  
Albany, New York

REDACTED

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PETER D. VAN BUREN  
Deputy Counsel  
Bureau of Professional Medical Conduct

## **EXHIBIT B**

### **Requirements for Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension of a Medical License**

1. Licensee shall immediately cease and desist from engaging in the practice of medicine in New York State, or under Licensee's New York license, in accordance with the terms of the Order. In addition, Licensee shall refrain from providing an opinion as to professional practice or its application and from representing that Licensee is eligible to practice medicine.
2. Within 5 days of the Order's effective date, Licensee shall deliver Licensee's current biennial registration to the Office of Professional Medical Conduct (OPMC) at Hedley Park Place, 433 River Street 4th Floor, Troy, NY 12180-2299.
3. Within 15 days of the Order's effective date, Licensee shall notify all patients of the cessation or limitation of Licensee's medical practice, and shall refer all patients to another licensed practicing physician for continued care, as appropriate. Licensee shall notify, in writing, each health care plan with which the Licensee contracts or is employed, and each hospital where Licensee has privileges, that Licensee has ceased medical practice. Within 45 days of the Order's effective date, Licensee shall provide OPMC with written documentation that all patients and hospitals have been notified of the cessation of Licensee's medical practice.
4. Licensee shall make arrangements for the transfer and maintenance of all patient medical records. Within 30 days of the Order's effective date, Licensee shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate and acceptable contact persons who shall have access to these records. Original records shall be retained for at least 6 years after the last date of service rendered to a patient or, in the case of a minor, for at least 6 years after the last date of service or 3 years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information in the record is kept confidential and is available only to authorized persons. When a patient or a patient's representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient (not to exceed 75 cents per page.) Radiographic, sonographic and similar materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of an inability to pay.
5. In the event that Licensee holds a Drug Enforcement Administration

(DEA) certificate for New York State, Licensee shall, within fifteen (15) days of the Order's effective date, advise the DEA, in writing, of the licensure action and shall surrender his/her DEA controlled substance privileges for New York State to the DEA. Licensee shall promptly surrender any unused DEA #222 U.S. Official Order Forms Schedules 1 and 2 for New York State to the DEA. All submissions to the DEA shall be addressed to Diversion Program Manager, New York Field Division, U.S. Drug Enforcement Administration, 99 Tenth Avenue, New York, NY 10011.

6. Within 15 days of the Order's effective date, Licensee shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement of the New York State Department of Health. Licensee shall destroy all prescription pads bearing Licensee's name. If no other licensee is providing services at Licensee's practice location, Licensee shall properly dispose of all medications.
7. Within 15 days of the Order's effective date, Licensee shall remove from the public domain any representation that Licensee is eligible to practice medicine, including all related signs, advertisements, professional listings (whether in telephone directories, internet or otherwise), professional stationery or billings. Licensee shall not share, occupy, or use office space in which another licensee provides health care services.
8. Licensee shall not charge, receive or share any fee or distribution of dividends for professional services rendered by Licensee or others while Licensee is barred from engaging in the practice of medicine. Licensee may be compensated for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Order's effective date.
9. If Licensee is a shareholder in any professional service corporation organized to engage in the practice of medicine, Licensee shall divest all financial interest in the professional services corporation, in accordance with New York Business Corporation Law. Such divestiture shall occur within 90 days. If Licensee is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of the Order's effective date.
10. Failure to comply with the above directives may result in a civil penalty or criminal penalties as may be authorized by governing law. Under N.Y. Educ. Law § 6512, it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when a professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, which include fines of up to \$10,000 for each specification of charges of which the Licensee is found guilty, and may include revocation of a suspended license.