Mount Sinai

PATIENT ACCESS REQUEST FOR MEDICAL INFORMATION

Patient's Name: _____
(Last) (First) (Middle)

Unit Number: _____ DOB: _____ Tel. No. ___/_____/_____
Month/Day/Year

Address: _____
(Street) (City) (State) (Zip Code)

Please request/check all that apply:
ACCESS REQUESTED ☐ on-site inspection ☐ record copy @ $.75/page

Records	**Bill**	**Date(s) of Service**	**Document(s)**
☐ Entire Designated Record Set	☐	_____	_____
☐ Inpatient Visit(s)	☐	_____	_____
☐ ED Visit(s)	☐	_____	_____
☐ Ambulatory Surgery	☐	_____	_____
☐ Outpatient Clinic – Manhattan	☐	_____	_____
▫ AHC	☐	_____	_____
▫ Dialysis	☐	_____	_____
▫ IMA	☐	_____	_____
▫ Jack Martin	☐	_____	_____
▫ NRC	☐	_____	_____
▫ OB/GYN	☐	_____	_____
▫ Pediatrics	☐	_____	_____
▫ Psychiatry	☐	_____	_____
▫ Radiation Oncology	☐	_____	_____
▫ Specialty _____		_____	_____
☐ Outpatient Clinic Queens	☐	_____	_____
▫ Family Health Associates	☐	_____	_____
▫ Senior Health Center	☐	_____	_____
▫ Industrial Health Center	☐	_____	_____
☐ FPA Practice/Provider:	☐	_____	_____
_____		_____	_____
_____		_____	_____
☐ X-ray Films/Reports	☐	_____	_____
☐ Pathology Slides/Reports	☐	_____	_____
☐ Other	☐	_____	_____

We will not condition treatment or payment on whether you sign this authorization. However, if you refuse to sign we will not release your records.

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Mount Sinai provide me with access to health information in the manner described above. I understand that I will be contacted if any fees for a summary or explanation may be charged for fulfilling this request, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

Patient _____ Date: _____
Signature

Personal Representative _____ PRINT NAME: _____
Signature

Authority: _____ Date:_____

Address: _____ Tel No._____

{Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf}.

Need By: _____ Reason: _____

Send completed form to the most appropriate area listed below:

☐ Mount Sinai Hospital
Medical Records
One Gustave L. Levy Place – Box 1111
New York, N.Y. 10029

☐ FPA Patient Rights Coordinator
One Gustave L. Levy Place – Box 1061
New York, NY 10029

☐ Mount Sinai Hospital Queens
Medical Records
25-10 30th Avenue
Long Island City, NY 11102

☐ Northshore Medical Group
Medical Records
325 Park Avenue Huntington, NY
Huntington, NY 11743

☐ Other: _____
_____
_____

For (Hospital) Use Only

Date Received: (MO/DY/YR) _____/_____/_____

Disposition of Request: _____ GRANTED _____ DENIED _____ PARTIALLY DENIED

Patient Notified in Writing Of Response On This Date: (MO/DY/YR) _____/_____/_____

Fee Charged For Fulfilling This Request (if applicable): $ _____

Name or Initials of Records Department Staff Member Processing This Request: _____

☐ Mail Out ☐ Will Pick Up

1- Medical Records Copy 2 - Patient Copy