PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY IN SUPPORT OF APPLICATION FOR MEDICAL EXEMPTION FROM COVID-19 VACCINE

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

Date of Birth: _____

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

Please request/check all that apply:

I authorize _____
(Provider Name and Phone Number)
to disclose medical information:

(Orally or in writing) as needed to support my application for a medical exemption from the covid-19 vaccination.

Records to be disclosed ____ do include ___ do not include HIV-related information. (Check one)

To: Committee on Exemptions and Employee Health Service, Mount Sinai Health System
ATTN: David D'Souza, MD, Director Employee Health Service or his designee
David.D'Souza@mountsinai.org
One Gustave L. Levy Place, NY, NY 10029
Telephone: (212) 420-2396

Reason for Disclosure X Patient Request X Other: to support patient request for exemption from covid-19 vaccine requirement
I understand that this authorization is valid for a period of one year and that it may be revoked by me at any time except to the extent that action has already been taken based on my authorization.

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV-related information, the recipient(s) is prohibited from redisclosing any HIV-related information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437/(212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient
Signature: _____ Date: _____

Personal Representative
Signature: _____ Print Name: _____

Authority: _____ Tel. No: _____

Address: _____ Date: _____

{Personal Representative to sign only if patient is a minor or incompetent}.