Patient Authorization For Release of Medical Information to Third Party

Mount Sinai

Please print patient information

Last Name _____ First Name _____ Middle Name _____

Name at Time of Treatment (if different than above) _____

Date of Birth (mm/dd/yyyy) _____ Phone Number _____ Email (optional) _____

Street Address _____ City and State _____ Zip Code _____

Location(s) of Service (check only those where you received services)

- ☐ The Mount Sinai Hospital
- ☐ Mount Sinai Beth Israel
- ☐ Mount Sinai Brooklyn
- ☐ Mount Sinai Morningside
- ☐ Mount Sinai Queens
- ☐ Mount Sinai South Nassau
- ☐ Mount Sinai West
- ☐ New York Eye and Ear Infirmary of Mount Sinai
- ☐ The Blavatnik Family Chelsea Medical Center
- ☐ Mount Sinai-Behavioral Health Center
- ☐ Mount Sinai-Union Square
- ☐ **Mount Sinai Doctors:**
  - ☐ Brooklyn
  - ☐ Bronx/Westchester
  - ☐ Manhattan/Queens
  - ☐ Staten Island
  - ☐ Florida
  - ☐ Long Island
- ☐ Other (please specify): _____

Please Fill In Information and Check All Boxes That Apply

Records/Information Requested	Date(s) of Service	Location(s) of Service
☐ **Inpatient Visit(s):**		
☐ Discharge Summary	_____	_____
☐ Operative Report	_____	_____
☐ Entire Record	_____	_____
☐ Other: _____	_____	_____
☐ Ambulatory Surgery		
☐ Operative Report	_____	_____
☐ Entire Record	_____	_____
☐ Other: _____	_____	_____
☐ Emergency Department (ER)	_____	_____
☐ **Outpatient Physician Office:**		
☐ Provider Name: _____	_____	_____
☐ **Outpatient Clinic:**		
☐ Clinic Name: _____	_____	_____
☐ **Test Results:**		
☐ Cardiac Cath Reports ☐ Radiology Reports ☐ Pathology Reports ☐ Laboratory		
☐ Cardiac Cath Films ☐ Radiology Images ☐ Pathology Slides		_____
☐ Other (please specify): _____	_____	_____

Records to be disclosed:			
☐ do include	☐ do not include	HIV-related information
☐ do include	☐ do not include	Alcohol and Drug Abuse records
☐ do include	☐ do not include	Psychiatric Records
☐ do include	☐ do not include	Genetic Testing Results

Authorizing Release of Records To

☐ Health Care Provider
☐ Law Enforcement
☐ Insurance Company or Designee
☐ Employer
☐ Attorney
☐ Court
☐ Other _____

_____
Name

_____
Address

Reasons for Disclosure: ☐ Patient Request ☐ Benefits Application ☐ Other: _____

Please Check Requested Format/Mode of Delivery

☐ **Paper/Mail** ☐ **Disc/Mail** ☐ **PDF/Email** Email to send record to **(required)**: _____

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.

I understand that this authorization is valid for one year from this date or until _____ and may be revoked by me at any time except to the extent Mount Sinai has already taken action based on my authorization.

I understand that requests for medical record copies are subject to reproduction fees allowed by laws and regulations, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

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/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the 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 or 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 Patient of the information and such information is no longer protected by federal health information privacy regulations.

Patient,* Guardian or Representative**

_____	_____	_____	_____	_____
Print Name	Signature	Date	Time	Relationship or "self"

_____ _____
Address Phone Number

* The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.
** Throughout this document, the term "representative" refers to a legally authorized representative.

Send Complete Form to the Most Appropriate Area Listed Below		
Site	**Address**	**Phone Number**
The Mount Sinai Hospital	The Mount Sinai Hospital | HIM/Medical Records One Gustave L. Levy Place, Box 1111, New York, NY 10029	212-241-7607
Mount Sinai Beth Israel	Mount Sinai Beth Israel | Health Information Management/Medical Records 150 East 42nd Street, Fifth Floor, Section D, New York, NY 10017	212-420-2665
Mount Sinai Brooklyn	Mount Sinai Brooklyn | Health Information Management 3201 Kings Highway, Brooklyn, NY 11234	718-951-2806
Mount Sinai Morningside	Mount Sinai Morningside | Health Information Management 1090 Amsterdam Avenue, 13th Floor, Suite B, New York, NY 10025	212-523-3265
Mount Sinai Queens	Mount Sinai Queens | HIM/Medical Records 25-10 30th Avenue, Long Island City, NY 11102	718-808-7683
Mount Sinai South Nassau	Mount Sinai South Nassau | Health Information Management One Healthy Way, Oceanside, NY 11572	516-632-3907
Mount Sinai West	Mount Sinai West | Health Information Management 1000 Tenth Avenue, New York, NY 10019	212-523-6623
New York Eye and Ear Infirmary of Mount Sinai	New York Eye and Ear Infirmary of Mount Sinai | Medical Records 310 East 14th Street, New York, NY 10003	212-979-4352
The Blavatnik Family Chelsea Medical Center	The Blavatnik Family Chelsea Medical Center Health Information Management 325 West 15th Street, New York, NY 10011	212-604-6045
Mount Sinai-Behavioral Health Center	Mount Sinai-Behavioral Health Center Health Information Management/Medical Records 150 East 42nd Street, Fifth Floor, Section D, New York, NY 10017	212-420-2665
Mount Sinai-Union Square	Mount Sinai-Union Square Health Information Management/Medical Records Attn: Outpatient Team 150 East 42nd Street, Fifth Floor, Section D, New York, NY 10017	212-420-2665
Mount Sinai Doctors	Call practice to obtain address information **OR** Mount Sinai Doctors | Medical Records One Gustave L. Levy Place, Box 1111, New York, NY 10029	Contact the individual practice or request your records online by entering the following web address in your browser: **swellbox.com/mtsinai-wizard.html**