PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO MOUNT SINAI

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

Date of Birth: ________________ Tel. No.:_____/_______/__________
Month/Day/Year

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

I authorize ____ to disclose my Protected Health Information from my medical records to ____ at Mount Sinai Brooklyn Heights Medical Group, 300 Cadman Plaza West, Brooklyn, NY 11201.

Reason for Disclosure: Continued care.

☐ Description of Information to be released:__________________________________

☐ Medical Records from ____________________ to ____________________ ☐ Entire Medical Record

Include (indicate by initialing): ______HIV-related information and test results ______Alcohol/Drug Treatment ______Mental Health Treatment (excluding psychotherapy notes)

I understand that treatment or payment will not be conditioned on whether I sign this authorization. However, if I refuse to sign, my records will not be released. 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 that action has 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 or state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization.

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: ______________

Legal Representative Signature: ________________________ Date: ______________

Legal Representative Name (print) ________________________

Address: ________________________________ Tel: ______________

Legal Representative Authority: ________________________

To request records or to revoke authorization, mail or fax written request to:
Mount Sinai Brooklyn Heights Medical Group, 300 Cadman Plaza West, Brooklyn, NY 11201
Fax (929) 210-6434

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.