I hereby authorize Mt. Sinai Morningside Hospital to furnish information concerning my illness and treatment to my insurance carrier.
Yo autorizo Mt. Sinai Morningside Hospital facilitar la informacion y el tratamiento a mi seguro

I hereby authorize payment of medical benefits to Mt. Sinai Morningside Hospital I understand that I am responsible for any part of the charges that are not covered by medical coverage.
Yo autorizo pagos de benefico medico a Mt. Sinai Morningside Hospital Yo afirmo que sere responsable por pagar mi porcion no cubierta por mi seguro medico

Signature of patient/ (Parent/Guardian if patient is a minor):____________________ Date__________