MOUNT SINAI USE OF INFORMATION AUTHORIZATION

Dear Patient,

Like other major academic medical centers, Mount Sinai depends greatly upon the generosity of our patients to help us provide the finest in patient care, educate the next generation of physicians, and promote research and discovery of new treatments and cures.

Federal law now requires health care providers to obtain your written authorization prior to contacting you with marketing information or about philanthropic initiatives that support the work of your doctors. Your permission for disclosure of your name will allow Mount Sinai staff to contact you about marketing or philanthropic efforts that may be of interest to you.

No other information about you or your medical treatment will be disclosed – that is strictly between you and your doctor. Maintaining patient confidentiality and ensuring your right to privacy has always been, and will always be, a priority at Mount Sinai.

We hope you will take a moment to read this authorization and sign below. If you have any questions, please call the Mount Sinai Development Office at (212) 659-8500.

Thank you.

I authorize any doctor employed by or on the staff of The Mount Sinai Hospital and Mount Sinai School of Medicine ("Mount Sinai") to disclose my name and contact information to Mount Sinai development and public affairs staff for the purpose of contacting me about Mount Sinai marketing and philanthropy opportunities. I understand that my health care treatment at Mount Sinai will not be affected in any way by my refusal or failure to sign this form. I further understand that this authorized information will not be released to any third parties for any purpose other than that expressed above. This authorization will remain in effect for five years. However, I may revoke this authorization at any time by writing to the Mount Sinai Development Office, One Gustave L. Levy Place, Box 1049, New York, New York 10029-6574. By signing below, I acknowledge that I have read and accept all of the above.

X_____	X_____	X_____
Signature of Patient or Personal Representative/Guardian	***Print Name*** of Patient or Personal Representative/Guardian	***Date***

X_____

Address *of Patient*

_____

If Applicable, Description of Authority of Personal Representative/Guardian

_____

E-mail Address *of Patient*

A signed copy of this form is available upon request by patient or patient representative

MR-212 (REV 4/06) *MRN #:* *OFFICE USE ONLY* _____