



Mount Sinai

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY

PLEASE PRINT PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE:
Name at Time of Treatment (If different than above)		
Date of Birth (MM/DD/YYYY):	Phone:	Email (optional):
Street Address:	City & State:	Zip Code:

LOCATION(S) OF SERVICE (check only those where you received services):

<input type="checkbox"/> Mount Sinai Beth Israel	<input type="checkbox"/> Mount Sinai Hospital
<input type="checkbox"/> Mount Sinai Queens	<input type="checkbox"/> New York Eye and Ear Infirmary at Mount Sinai
<input type="checkbox"/> Mount Sinai West (aka Roosevelt)	<input type="checkbox"/> Mount Sinai Brooklyn (aka Kings Highway)
<input type="checkbox"/> Mount Sinai St. Luke's	<input type="checkbox"/> Mount Sinai Union Square
<input type="checkbox"/> Mount Sinai Chelsea	<input type="checkbox"/> Other - Please Specify: _____
<input type="checkbox"/> Mount Sinai Doctors Faculty Practice:	
<input type="checkbox"/> Long Island	<input type="checkbox"/> Manhattan/Queens
<input type="checkbox"/> Brooklyn	<input type="checkbox"/> Bronx/Westchester
<input type="checkbox"/> Staten Island	

PLEASE FILL IN INFORMATION AND CHECK ALL BOXES THAT APPLY

Records/Information Requested	Date(s) of Service	Location(s) of Service
<input type="checkbox"/> Inpatient Visit(s):		
<input type="checkbox"/> Discharge Summary	_____	_____
<input type="checkbox"/> Operative Report		
<input type="checkbox"/> Entire Record		
<input type="checkbox"/> Other _____		
<input type="checkbox"/> Ambulatory Surgery		
<input type="checkbox"/> Operative Report		
<input type="checkbox"/> Entire Record		
<input type="checkbox"/> Other _____		
<input type="checkbox"/> Emergency Department (ER)	_____	_____
<input type="checkbox"/> Outpatient Physician Office		
<input type="checkbox"/> Provider Name _____	_____	_____
<input type="checkbox"/> Outpatient Clinic		
<input type="checkbox"/> Clinic Name _____	_____	_____
<input type="checkbox"/> Test Results:		
<input type="checkbox"/> Cardiac Cath Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Cardiac Cath Films	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Pathology Slides
<input type="checkbox"/> Other _____	_____	_____
Records to be disclosed:	<input type="checkbox"/> do include	<input type="checkbox"/> do not include HIV-related information
	<input type="checkbox"/> do include	<input type="checkbox"/> do not include Alcohol and Drug Abuse records
	<input type="checkbox"/> do include	<input type="checkbox"/> do not include Psychiatric Records
	<input type="checkbox"/> do include	<input type="checkbox"/> do not include Genetic Testing Results



Mount Sinai

Authorizing release of records to:

Healthcare Provider Insurance Company or Designee Attorney Court

Law Enforcement Employer Other: _____

Name: _____

Address: _____

Reason 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/ (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 Signature: _____ Date: _____

Personal Representative (Personal Representative to sign only if patient is a minor or unable to sign on his/her behalf)

Signature: _____ Print Name: _____

Authority: _____ Tel. No: _____

Address: _____ Date: _____



SEND COMPLETE FORM TO THE MOST APPROPRIATE AREA LISTED BELOW

Site	Address	Telephone 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 Queens	Mount Sinai Queens HIM/Medical Records 25-10 30th Avenue Long Island City, NY 11102	718-808-7683
Mount Sinai Beth Israel	Mount Sinai Beth Israel Health Information Management First Avenue at 16th Street New York, NY 10003	212-420-2665 x-0
Mount Sinai Brooklyn	Mount Sinai Brooklyn Health Information Management 3201 Kings Highway Brooklyn, NY 10025	718-951-2806
Mount Sinai Doctors Faculty Practice	Make requests directly to the practice – Call practice to obtain address information OR Mount Sinai Doctors Faculty Practice – Medical Records 1 Gustave L. Levy Place, Box 1111 New York, NY 10029	Individual Practice
Mount Sinai Union Square	Mount Sinai Beth Israel Health Information Management First Avenue at 16th Street New York, NY 10003 Attn: Outpatient Team	212-844-5275
Mount Sinai St. Luke's	Mount Sinai St. Luke's Health Information Management 1111 Amsterdam Avenue New York, NY 10025	212-523-3265
Mount Sinai West	Mount Sinai West Health Information Management 1000 Tenth Avenue New York, NY 10019	212-523-6623
Mount Sinai Chelsea	Mount Sinai Downtown Chelsea Health Information Management 325 West 15th Street New York, New York 10011	212-604-6045
New York Eye and Ear Infirmary	New York Eye and Ear Infirmary Medical Records 310 East 14th Street New York, NY 10003	212-979-4352