Mount Sinai West
AUTHORIZATION FOR RELEASE/PATIENT ACCESS OF MEDICAL INFORMATION

M.R. #_____

PATIENT NAME_____DATE OF BIRTH_____S.S. #_____

STREET, APT #_____

CITY, STATE, ZIP CODE_____TELEPHONE #_____

1. I hereby authorize the Medical Records Department staff at Mount Sinai West to release information from my medical record to (If self please indicate below):

2. NAME_____

   ADDRESS_____

   CITY, STATE, ZIP CODE_____

   For the purpose of (please check one)

   _____Continued Treatment _____Legal Review _____Insurance purpose

   _____Personal review of information _____Other (please specify) _____

3. I limit the information to be released to the following items: (Please check specific items)

   _____Discharge Summary _____Consultation _____Diagnostic test (e.g. Lab, X-ray, Radiology)
   (Please specify)_____

   _____Operative Note _____Pathology

   _____Other (please specify) _____

   _____Emergency Department Record _____Outpatient Record
   (Please specify)_____

Covering records from on or about (Date)_____to (Date)_____

CONFIDENTIAL INFORMATION

4. If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:
   _____ I understand that if my record contains **information concerning mental health and/or drug and alcohol treatment**, such information will be released pursuant to this authorization.
   _____ I understand that if my record contains **confidential HIV related information**, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

5. I know I do not have to allow release of HIV related information and that I can change my mind at any time before it is released. If I experience discrimination because of release of HIV confidential information, I can call the NYS Division of Human Rights at (212) 480-2493 and/or the NYC Commission of Human Rights at (212) 306-7450.

6. **This authorization will automatically expire within six months from the date of signature**. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department at Mount Sinai West. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your heath care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

8. I also understand that in an effort to prevent unauthorized re-disclosure, Mount Sinai West attaches a notice when sending out records that states, "re-disclosure is prohibited". However, the potential for an unauthorized re-disclosure may not be protected by federal confidentiality rules.

9. I also understand that in order to process this request to reproduce medical record information on a timely basis, Mount Sinai West, in which I am requesting information from, may utilize a photocopy service and my signature authorizes the release of information to such photocopy service for the purpose of satisfying this request.

_____ _____
(Signature of Patient/ Representative/ or Legal Guardian) (Date)

_____ _____
(If other than patient, relationship to patient) (Notary/ Witness)