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):

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

PLEASE FILL IN INFORMATION AND CHECK ALL BOXES THAT APPLY

Records/Information Requested	**Date(s) of Service**	**Location(s) of Service**
☐ Inpatient Visit(s): ☐ Discharge Summary ☐ Operative Report ☐ Entire Record ☐ Other_____	_____	_____
☐ Ambulatory Surgery ☐ Operative Report ☐ Entire Record ☐ Other_____	_____	_____
☐ Emergency Department (ER)	_____	_____
☐ Outpatient Physician Office ☐ Provider Name _____	_____	_____
☐ Outpatient Clinic ☐ Clinic Name _____	_____	_____
☐ Test Results: ☐ Cardiac Cath Reports ☐ Radiology Reports ☐ Pathology Reports ☐ Laboratory ☐ Cardiac Cath Films ☐ Radiology Images ☐ Pathology Slides		_____
☐ Other_____	_____	_____

Records to be disclosed:		
	☐ do include	☐ do not include HIV-related information
	☐ do include	☐ do not include Alcohol and Drug Abuse records
	☐ do include	☐ do not include Psychiatric Records
	☐ do include	☐ do not include Genetic Testing Results

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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: _____

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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 11234	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 1090 Amsterdam Avenue 13th floor, Suite B New, 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