

Patient Access Request for Medical Information



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 and State

Zip Code

Location(s) of Service (check only those where you received services):

- | | | |
|--|---|--|
| <input type="checkbox"/> The Mount Sinai Hospital | <input type="checkbox"/> New York Eye and Ear Infirmary
at Mount Sinai | <input type="checkbox"/> Other—Please specify:
_____ |
| <input type="checkbox"/> Mount Sinai Beth Israel | <input type="checkbox"/> Mount Sinai Brooklyn | <input type="checkbox"/> Mount Sinai Doctors:
_____ |
| <input type="checkbox"/> Mount Sinai Queens | <input type="checkbox"/> Mount Sinai-Union Square | <input type="checkbox"/> Long Island <input type="checkbox"/> Manhattan/Queens <input type="checkbox"/> Brooklyn |
| <input type="checkbox"/> Mount Sinai West | <input type="checkbox"/> Mount Sinai-Behavioral
Health Center | <input type="checkbox"/> Bronx/Westchester <input type="checkbox"/> Staten Island <input type="checkbox"/> Florida |
| <input type="checkbox"/> Mount Sinai Morningside | <input type="checkbox"/> Mount Sinai South Nassau | |
| <input type="checkbox"/> The Blavatnik Family Chelsea
Medical Center at Mount Sinai | | |

Please Fill In Information and Check All Boxes that Apply

Records/Information Requested	Date(s) of Service	Location(s) of Service
<input type="checkbox"/> Entire Medical Record	_____	_____
<input type="checkbox"/> Inpatient Visit(s):		
<input type="checkbox"/> Discharge Summary	_____	_____
<input type="checkbox"/> Operative Report	_____	_____
<input type="checkbox"/> Ambulatory Surgery	_____	_____
<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"/> Designated Record Set	_____	_____
<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"/> Laboratory
<input type="checkbox"/> Pathology Slides	_____	_____
<input type="checkbox"/> Other:	_____	_____

Purpose of Request: Self Continuing Treatment Benefits Other: _____

Please Check Requested Format/Mode of Delivery

Paper: Mail Pickup **Disc:** Mail Pickup Onsite Inspection

Electronic: PDF/Email: Email to send record to (REQUIRED): _____

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The Mount Sinai Health System responds to patient access requests in accordance with HIPAA and NYS laws. 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.

Patient Understanding and Signature

By signing below, I am requesting that Mount Sinai provide me with access to health information in the manner described above. 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.

Signature of Patient or Personal Representative: _____ Date: _____
(Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf)

Personal Representative Print Name: _____ Relationship/Authority: _____

Address: _____ Telephone Number: _____

Send Complete Form to the most appropriate area listed below

Site	Address	Contact Information
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, Astoria, NY 11102	718-808-7683
Mount Sinai Beth Israel	Mount Sinai Beth Israel Health Information Management 281 First Avenue (First Avenue at 16th Street), New York, NY 10003	212-420-2665 x-0
Mount Sinai-Behavioral Health Center	Mount Sinai-Behavioral Health Center Health Information Management 281 First Avenue (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	Call practice to obtain address information - OR - Mount Sinai Doctors Medical Records One Gustave L. Levy Place, Box 1111, New York, NY 10029	Contact the individual practice or request your records online by entering the following web address in your browser: https://www.swellbox.com/mtsinai-wizard.html
Mount Sinai-Union Square	Mount Sinai Beth Israel Health Information Management 281 First Avenue (First Avenue at 16th Street), New York, NY 10003 Attn: Outpatient Team	212-844-5275
Mount Sinai Morningside	Mount Sinai Morningside Health Information Management 1090 Amsterdam Avenue, 13th floor, Suite B, 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 South Nassau	Mount Sinai South Nassau Health Information Management One Healthy Way, Oceanside, NY 11572	516-632-3907
The Blavatnik Family Chelsea Medical Center at Mount Sinai	The Blavatnik Family Chelsea Medical Center at Mount Sinai Health Information Management 325 West 15th Street, New York, NY 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