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 and State Zip Code

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

☐ Mount Sinai Beth Israel
☐ Mount Sinai Queens
☐ Mount Sinai West
☐ Mount Sinai Morningside
☐ The Blavatnik Family Chelsea Medical Center at Mount Sinai
☐ The Mount Sinai Hospital
☐ New York Eye and Ear Infirmary at Mount Sinai
☐ Mount Sinai Brooklyn
☐ Mount Sinai-Union Square
☐ Mount Sinai South Nassau
☐ Other–Please specify: ____________________
☐ Mount Sinai Doctors:
☐ Long Island ☐ Manhattan/Queens ☐ Brooklyn
☐ Bronx/Westchester ☐ Staten Island ☐ Florida

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 ☐ Cardiac Cath Films ☐ Radiology Reports ☐ Radiology Images ☐ Pathology Reports ☐ Pathology Slides ☐ Laboratory

☐ 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 excpept to the extent Mount Sinai has already taken action based on my authorization.

I understand that requests for medical record copies ar 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 wnat 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	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**