



MOUNT SINAI  
SCHOOL OF  
MEDICINE



North Shore  
Medical Group



The Mount Sinai  
Hospital  
of Queens

A Division of The Mount Sinai Hospital



Diagnostic  
and  
Treatment  
Center

**PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY**

Patient's  
Name: \_\_\_\_\_  
(Last) (First) (Middle)

Unit Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Tel. No.: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month/Day/Year

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Please request/check all that apply:

I authorize Mount Sinai to disclose medical information about my:

- Manhattan  Queens  Huntington

\_\_\_ Emergency Room visit on: \_\_\_\_\_ Date(s)

\_\_\_ OPD Clinic visit, specify clinic: \_\_\_\_\_ Date(s)

\_\_\_ FPA Practice/Provider \_\_\_\_\_  
Name of Provider Date(s)

\_\_\_ Hospitalization from: \_\_\_\_\_ to \_\_\_\_\_  
Admission Date(s) Discharge Date(s)

\_\_\_ Ambulatory Surgery: Date: \_\_\_\_\_

\_\_\_ Specify (i.e. Lab tests, Operative Reports) \_\_\_\_\_ Date \_\_\_\_\_

Records to be disclosed \_\_\_ do include \_\_\_ do not include HIV-related information. (check one)

- To  Healthcare Provider  Insurance Company or Designee  Attorney  
 Court  Law Enforcement  Employer

Other: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for Disclosure  Patient Request  Other: \_\_\_\_\_

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.

1 - Medical Record Copy 2- Patient Copy

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.

### 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-related information, the recipient(s) is prohibited from redisclosing any HIV-related 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 of the information, and such information is no longer protected by federal health information privacy regulations.

Patient  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative  
Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Authority: \_\_\_\_\_ Tel. No: \_\_\_\_\_

Address: \_\_\_\_\_ Date: \_\_\_\_\_

{Personal Representative to sign only if patient is a minor or incompetent}.

To request records or to revoke authorization send a written request to:

Mount Sinai Hospital  
Medical Records  
One Gustave L. Levy Place – Box 1111  
New York, NY 10029

Faculty Practice Associates  
Patient Rights Coordinator  
One Gustave L. Levy Place – Box 1621  
New York, NY 10029

Mount Sinai Hospital Queens  
Medical Records  
25-10 30<sup>th</sup> Avenue  
Long Island City, NY 11102

Northshore Medical Group  
Medical Records  
Huntington, NY

#### For Mount Sinai Use Only

Date Received: (MO/DY/YR) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Disposition of Request: \_\_\_\_\_ GRANTED \_\_\_\_\_ DENIED \_\_\_\_\_ PARTIALLY DENIED

Patient Notified in Writing Of Response On This Date: (MO/DY/YR) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Fee Charged For Fulfilling This Request (if applicable): \$ \_\_\_\_\_

Name or Initials of Records Department Staff Member Processing This Request: \_\_\_\_\_

Mail Out                       Will Pick Up  
1 – Medical Records Copy                      2 – Patient Copy