Mount Sinai

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO MOUNT SINAI

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 _____ to disclose medical information about my:

___Emergency Room visit on: _____
Date(s)

___OPD Clinic visit, specify clinic: _____
Date(s)

___Private MD/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 ☐ _____

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.

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 unable to sign on his/her own behalf}.

To request records or to revoke authorization sends a written request to releasing provider

1 – Medical Records Copy 2 – Patient Copy