**PATIENT AUTHORIZATION TO USE/DISCLOSE PHOTOGRAPHS/VIDEOS/BROADCAST**

Patient's Name: ______________________________________________
(Last) (First) (Middle)

Unit Number: ________________ Date of Birth: __________________ Phone ___/_____/___________
Month/Day/Year

Address: ______________________________________________
(Street) (City) (State) (Zip Code)

Please request/check all that apply:

I authorize Mount Sinai to use or disclose the photograph or video taken of me during my:

___________ Emergency Room visit on: ___________________________________
Date(s)

___________ OPD Clinic visit, specify clinic: ___________________________________
Date(s)

___________ FPA Practice visit on: ___________________________________
Date(s)

___________ Hospitalization from: ____________________ to ____________________
Admission Date(s) Discharge Date(s)

___________ Ambulatory Surgery:__________________________ ______Date: ___________

___________ Other _______________________ Date_____________________

at ☐ Manhattan ☐ Queens ☐ Huntington

☐ within the institution

☐ for live broadcast at:______________________________

☐ Other: ___________________________________

Reason for Disclosure ☐ Patient Request ☐ Teaching ☐ Other:_________________________

Photographs/videos to be used/disclosed ____ do include ____ do not include HIV-related information. (check one)

1 – Medical Record Copy 2- Patient Copy

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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 extend 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 or state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization.

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: ___________________________________

Or

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 revoke authorization send a written request to:

Mount Sinai Hospital
Medical Records
One Gustave L. Levy Place – Box 1111
New York, NY 10028

FPA
Medical Records
One Gustave L. Levy Place – Box 1061
New York, NY 10028

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

Northshore Medical Group
Medical Records
325 Park Avenue
Huntington, NY 11743

**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: ________________________

1 – Medical Records Copy 2 – Patient Copy

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