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

**PLEASE PRINT PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST NAME:</th>
<th>MIDDLE:</th>
</tr>
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<tbody>
<tr>
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</table>

**Name at Time of Treatment (If different than above)**

**Date of Birth (MM/DD/YYYY):**

**Phone:**

**Email (optional):**

**Street Address:**

**City & State:**

**Zip Code:**

**LOCATION(S) OF SERVICE** (check only those where you received services):

- [ ] Mount Sinai Beth Israel
- [ ] Mount Sinai Queens
- [ ] Mount Sinai West (aka Roosevelt)
- [ ] Mount Sinai St. Luke’s
- [ ] Mount Sinai Chelsea
- [ ] Mount Sinai Doctors Faculty Practice:
  - [ ] Long Island
  - [ ] Manhattan/Queens
  - [ ] Brooklyn
  - [ ] Bronx/Westchester
  - [ ] Staten Island

**PLEASE FILL IN INFORMATION AND CHECK ALL BOXES THAT APPLY**

<table>
<thead>
<tr>
<th>Records/Information Requested</th>
<th>Date(s) of Service</th>
<th>Location(s) of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Visit(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Discharge Summary</td>
<td></td>
<td></td>
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<tr>
<td>❑ Operative Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑ Entire Record</td>
<td></td>
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<tr>
<td>❑ Other ____________________</td>
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<tr>
<td><strong>Ambulatory Surgery</strong></td>
<td></td>
<td></td>
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<tr>
<td>❑ Operative Report</td>
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<tr>
<td>❑ Entire Record</td>
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<tr>
<td>❑ Other ____________________</td>
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<tr>
<td><strong>Emergency Department (ER)</strong></td>
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<tr>
<td><strong>Outpatient Physician Office</strong></td>
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<td></td>
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<tr>
<td>❑ Provider Name ______________</td>
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<tr>
<td><strong>Outpatient Clinic</strong></td>
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<tr>
<td>❑ Clinic Name ________________</td>
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<tr>
<td><strong>Test Results:</strong></td>
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<tr>
<td>❑ Cardiac Cath Reports</td>
<td></td>
<td></td>
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<tr>
<td>❑ Radiology Reports</td>
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<td></td>
</tr>
<tr>
<td>❑ Pathology Reports</td>
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<tr>
<td>❑ Laboratory</td>
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<tr>
<td>❑ Cardiac Cath Films</td>
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<tr>
<td>❑ Radiology Images</td>
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<tr>
<td>❑ Pathology Slides</td>
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<tr>
<td>❑ Other ____________________</td>
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</tr>
</tbody>
</table>

**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

MR-201 (REV 07/2018)
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 except to the extent Mount Sinai has already taken action based on my authorization.

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.

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 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: __________________________
<table>
<thead>
<tr>
<th>Site</th>
<th>Address</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>
| 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
Long Island City, NY 11102       | 718-808-7683         |
| Mount Sinai Beth Israel          | Mount Sinai Beth Israel
Health Information Management
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 Faculty Practice | Make requests directly to the practice –
Call practice to obtain address information
OR
Mount Sinai Doctors Faculty Practice – Medical Records
1 Gustave L. Levy Place, Box 1111
New York, NY 10029            | Individual Practice       |
| Mount Sinai Union Square         | Mount Sinai Beth Israel
Health Information Management
First Avenue at 16th Street
New York, NY 10003
Attn: Outpatient Team             | 212-844-5275         |
Health Information Management
1090 Amsterdam Avenue
13th floor, Suite B
New, 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 Chelsea              | Mount Sinai Downtown Chelsea
Health Information Management
325 West 15th Street
New York, New York 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         |