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 & 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
- ☒ Mount Sinai Hospital
- ☐ New York Eye and Ear Infirmary at Mount Sinai
- ☐ Mount Sinai Brooklyn (aka Kings Highway)
- ☐ Mount Sinai Union Square
- ☒ Other - Please Specify: West Care Pediatrics 2 West 86th Street

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 West Care Pediatrics	Birth-present	2 West 86th Street
☐ Outpatient Clinic		
☐ Clinic Name		
☐ Test Results:		
☐ Cardiac Cath Reports ☐ Radiology Reports ☐ Pathology Reports ☐ Laboratory		
☐ Cardiac Cath Films ☐ Radiology Images ☐ Pathology Slides		
☐ 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

Mount
Sinai

Authorizing release of records to:

☒ Healthcare Provider ☐ Insurance Company or Designee ☐ Attorney ☐ Court

☐ Law Enforcement ☐ Employer ☐ Other: ______

Name: Manhattan Valley Pediatrics

Address: 2637 Broadway NY, NY 10025

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): info@manhattanvalleypediatrics.com

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 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: ______