



Mount Sinai

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):

<input type="checkbox"/> Mount Sinai Beth Israel	<input checked="" type="checkbox"/> Mount Sinai Hospital
<input type="checkbox"/> Mount Sinai Queens	<input type="checkbox"/> New York Eye and Ear Infirmary at Mount Sinai
<input checked="" type="checkbox"/> Mount Sinai West (aka Roosevelt)	<input type="checkbox"/> Mount Sinai Brooklyn (aka Kings Highway)
<input type="checkbox"/> Mount Sinai St. Luke's	<input type="checkbox"/> Mount Sinai Union Square
<input type="checkbox"/> Mount Sinai Chelsea	<input checked="" type="checkbox"/> Other - Please Specify: <u>West Care Pediatrics</u>
<input type="checkbox"/> Mount Sinai Doctors Faculty Practice:	<u>2 West 86th Street</u>
<input type="checkbox"/> Long Island	<input type="checkbox"/> Manhattan/Queens
<input type="checkbox"/> Brooklyn	<input type="checkbox"/> Bronx/Westchester
<input type="checkbox"/> Staten Island	

PLEASE FILL IN INFORMATION AND CHECK ALL BOXES THAT APPLY

Records/Information Requested	Date(s) of Service	Location(s) of Service
<input checked="" type="checkbox"/> Inpatient Visit(s):		
<input type="checkbox"/> Discharge Summary		
<input type="checkbox"/> Operative Report		
<input type="checkbox"/> Entire Record		
<input type="checkbox"/> Other _____		
<input checked="" type="checkbox"/> Ambulatory Surgery		
<input type="checkbox"/> Operative Report		
<input type="checkbox"/> Entire Record		
<input type="checkbox"/> Other _____		
<input checked="" type="checkbox"/> Emergency Department (ER)		
<input checked="" type="checkbox"/> Outpatient Physician Office		
<input type="checkbox"/> Provider Name <u>West Care Pediatrics</u>	<u>Birth-present</u>	<u>2 West 86th Street</u>
<input type="checkbox"/> Outpatient Clinic		
<input type="checkbox"/> Clinic Name _____		
<input type="checkbox"/> Test Results:		
<input type="checkbox"/> Cardiac Cath Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Cardiac Cath Films	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Pathology Slides
<input type="checkbox"/> Laboratory		
<input type="checkbox"/> Other _____		
Records to be disclosed:	<input type="checkbox"/> do include	<input checked="" type="checkbox"/> do not include HIV-related information
	<input type="checkbox"/> do include	<input checked="" type="checkbox"/> do not include Alcohol and Drug Abuse records
	<input type="checkbox"/> do include	<input checked="" type="checkbox"/> do not include Psychiatric Records
	<input type="checkbox"/> do include	<input checked="" type="checkbox"/> 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: _____