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):

- ☐ 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: _____

**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 _____ | _____ | _____ |
| ☐ Outpatient Clinic ☐ Clinic Name _____ | _____ | _____ |
| ☐ Test Results: ☐ Cardiac Cath Reports ☐ Cardiac Cath Films ☐ Radiology Reports ☐ Radiology Images ☐ Pathology Reports ☐ Pathology Slides ☐ Laboratory | | _____ |
| ☐ 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

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**Authorizing release of records to:**

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

☐ Law Enforcement ☐ Employer ☑ Other: Agent for Attorney

Name: RECORDS DEPOSITION SERVICE, INC.

Address: P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

**Reason for Disclosure** ☐ Patient Request ☐ Benefits Application ☑ Other: LEGAL

**PLEASE CHECK REQUESTED FORMAT/MODE OF DELIVERY**

☐ **PAPER/MAIL** ☐ **DISC/MAIL** ☑ **PDF/EMAIL:** Email to send record to (REQUIRED): INFO@RECDEP.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: _____