



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.

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Mount Sinai provide me with access to health information in the manner described above. I understand that I will be contacted if any fees for a summary or explanation may be charged for fulfilling this request, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

Patient \_\_\_\_\_ Date: \_\_\_\_\_  
Signature

Personal Representative \_\_\_\_\_ PRINT NAME: \_\_\_\_\_  
Signature

Authority: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Tel No. \_\_\_\_\_

Need By: \_\_\_\_\_ Reason: \_\_\_\_\_

Send completed form to the most appropriate area listed below:

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

FPA Patient Rights Coordinator  
One Gustave L. Levy Place – Box 1061  
New York, NY 10028

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

Northshore Medical Group  
Medical Records  
Huntington, NY

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For (Hospital) 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: \_\_\_\_\_

Mail Out

Will Pick Up

1- Medical Records Copy

2 - Patient Copy