A proud member of Sinai Health System

SINAI

MOUNT SINAI HOSPITAL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:	Birth Date:	Medical Record #-
Social Security No. (optional):	Recipient's Name:	
Entity: (check all that apply) ☐ Mt. Sinai Hospital ☐ Schwab Rehab ☐ Sinai Medical Group	Address City: State: Zip:	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: Event

The information for which I am authorizing disclosure will be used for the following purpose:	Insurance:
☐ My personal records ☐ Sharing with other health care providers as needed ☐ Marketing purposes (please describe below) ☐ Other (please describe):	_____ _____ _____

If the request of PHI is for the purpose of marketing will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? If yes, describe:

Description Of Information To Be Used Or Disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ Immunization records ☐ Most recent history and physical ☐ Most recent discharge summary ☐ Operative report		☐ X-ray and imaging reports (please describe) _____ ☐ Lab results (please describe) _____		☐ Consultation reports (please supply doctors name) _____ ☐ Entire record ☐ Other (please describe) _____	

I UNDERSTAND THAT:

1. **I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.**
2. **I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**
3. **I understand that once the above information is disclosed, it may beredisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.**
4. **I understand that I may see and obtain a copy of the information described on the form for a reasonable copy fee if I ask for it.**
5. **I will receive a copy of this form after I sign it.**

I have read the above and authorize the disclosure of the protected health information as stated.

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, **HIV** results or AIDS information. _____ (Initial)

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's/Representative	Relationship to Patient: