



Attn: Georgette Smith



**PATIENT ACCESS REQUEST FOR MEDICAL INFORMATION**

Patient's Name: \_\_\_\_\_  
(Last) (First) (Middle)

Unit Number: \_\_\_\_\_ DOB: \_\_\_\_\_ Tel. No. \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month/Day/Year

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Please request/check all that apply:

ACCESS REQUESTED  on-site inspection  record copy @ \$.75/page

**Records**

**Bill**

**Date(s) of Service**

**Document(s)**

Entire Designated Record Set

Inpatient Visit(s)

ED Visit(s)

Ambulatory Surgery

Outpatient Clinic - Manhattan

▫ AHC

▫ Dialysis

▫ IMA

▫ Jack Martin

▫ NRC

▫ OB/GYN

▫ Pediatrics

▫ Psychiatry

▫ Radiation Oncology

▫ Specialty \_\_\_\_\_

Outpatient Clinic Queens

▫ Family Health Associates

▫ Senior Health Center

▫ Industrial Health Center

FPA Practice/Provider:  
\_\_\_\_\_  
\_\_\_\_\_

X-ray Films/Reports

Pathology Slides/Reports

Other

- CTA/CT SCAN
- MRI - MRA
- ULTRA-SOUND
- PET SCAN
- X-RAY
- BONE DENSITY
- MAMMO
- CD
- REPORT
- PICK UP
- MAIL TO HOME
- MAIL TO OTHER

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. \_\_\_\_\_

{Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf}

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, NY 10029

FPA Patient Rights Coordinator  
One Gustave L. Levy Place - Box 1061  
New York, NY 10029

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

Northshore Medical Group  
Medical Records  
325 Park Avenue Huntington, NY  
Huntington, NY 11743

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

<b>For (Hospital) Use Only</b>	
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