Mount Sinai

Mount Sinai The Mount Sinai Hospital of Queens
A Division of The Mount Sinai Hospital

M S

Attn: Georgette Smith
[redacted]
Medical Records
Fax No. [redacted]

PATIENT ACCESS REQUEST FOR MEDICAL INFORMATION

Patient's Name: _____
(Last) (First) (Middle)

Unit Number: _____ Date of Birth: _____ 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

_____ _____
_____ _____

MR-200 (3/03) 1- Medical Records Copy 2- Patient Copy

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 Signature _____ * Date: _____

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 30th 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