



Mount Sinai

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY

Patient's Name: Epstein Jeffrey
(Last) (First) (Middle)

Unit Number: _____ Birth: [Redacted] Tel. No.: 2127509895
Month/Day/Year

Address: 9 East 71st Street, New York, NY 10021
(Street) (City) (State) (Zip Code)

Please request/check all that apply:

I authorize Mount Sinai to disclose medical information about my:

- Manhattan
- Queens
- Huntington

___ Emergency Room visit on: _____ Date(s)

___ OPD Clinic visit, specify clinic: _____ Date(s)

___ FPA Practice/Provider _____ Name of Provider Date(s)

___ Hospitalization from: _____ to _____ Admission Date(s) Discharge Date(s)

___ Ambulatory Surgery: Date: _____

___ Specify (i.e. Lab tests, Operative Reports) MRI's Date 12/14/2016

- Records to be disclosed ___ do include ___ do not include HIV-related information. (check one)
- ___ do include ___ do not include Alcohol and Drug Abuse records. (check one)
- ___ do include ___ do not include Psychiatric information. (check one)

To Healthcare Provider Insurance Company or Designee Attorney

- Court
- Law Enforcement
- Employer

Other: Personal Assistant

Name: Lesley Groff

Address: 9 East 71st Street, NY, NY 10021

Reason for Disclosure Patient Request 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.

1 - Medical Record Copy 2- Patient Copy