Mount Sinai

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY

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

Unit Number: _____ Date of Birth [redacted] Month/Day/Year Tel. No.: ___/___/2127509895

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: _____ Admission Date(s) to _____ 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: _____

Name: Dr. Bruce Moskowitz

Address: 1411 N. Flagler Dr, Suite 7100, West Palm Beach, FL 33401

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

MR-201 (REV 3/15)