

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: NOV. 15, 2013
Signature

Personal Representative Lesley Groff PRINT NAME: LESLEY GROFF
Signature

Authority: PERSONAL ASSISTANT Date: NOV. 15, 2013

Address: 9 EAST 71ST ST, NY, NY 10021 Tel No. _____

Need By: NOV. 15, 2013 Reason: DOCTOR APPOINTMENT

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