



**Mount Sinai**  
Department of Radiology

Medical Records Office  
Mount Sinai Radiology Associates  
1176 Fifth Avenue, MC Level  
New York, NY 10029

**REQUEST FOR MOUNT SINAI RADIOLOGY/IMAGING RECORDS**, including studies performed at:

Mount Sinai Radiology Associates  
1176 Fifth Avenue, MC Level  
New York, NY 10029

Dubin Breast Center  
1176 Fifth Avenue, First Floor  
New York, NY 10029

Hess Center for Science & Medicine  
1470 Madison Avenue, SC2 level  
New York, NY 10029

Center for Advanced Medicine  
5-17 East 102nd Street  
New York, NY 10029

**PATIENT FOR WHOM RECORDS ARE BEING REQUESTED:**

LAST NAME: EPSTEIN FIRST NAME: JEFFREY MIDDLE NAME: EDWARD  
ADDRESS: 9 EAST 71ST CITY: NEW YORK STATE: NY ZIP CODE: 10021  
DATE OF BIRTH: 01/20/1953 MEDICAL RECORD NUMBER (IF KNOWN): [REDACTED] DAYTIME PHONE NUMBER (FOR QUESTIONS REGARDING THIS RECORD REQUEST): [REDACTED]

Exam Type	Body part (e.g., brain, left knee, etc.)	Exam Date	CD (\$25)	Paper Report
1. <input type="checkbox"/> CT/CTA <input type="checkbox"/> MRI/MRA <input type="checkbox"/> Ultrasound <input type="checkbox"/> PET <input type="checkbox"/> X-Ray <input type="checkbox"/> Bone Density <input type="checkbox"/> Mammogram <input checked="" type="checkbox"/> ALL RECENT RADIOLOGY IMAGING	CESTAMIBI TEST NUCLEAR TEST PARATHYROID	DEC. 13, 2017	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. <input type="checkbox"/> CT/CTA <input type="checkbox"/> MRI/MRA <input type="checkbox"/> Ultrasound <input type="checkbox"/> PET <input type="checkbox"/> X-Ray <input type="checkbox"/> Bone Density <input type="checkbox"/> Mammogram <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
3. <input type="checkbox"/> CT/CTA <input type="checkbox"/> MRI/MRA <input type="checkbox"/> Ultrasound <input type="checkbox"/> PET <input type="checkbox"/> X-Ray <input type="checkbox"/> Bone Density <input type="checkbox"/> Mammogram <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
4. <input type="checkbox"/> CT/CTA <input type="checkbox"/> MRI/MRA <input type="checkbox"/> Ultrasound <input type="checkbox"/> PET <input type="checkbox"/> X-Ray <input type="checkbox"/> Bone Density <input type="checkbox"/> Mammogram <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

**AUTHORIZATION**

(We will not condition treatment or payment on whether you sign this authorization. However, if you refuse to sign we cannot release these records.)

*By signing below, I am requesting that Mount Sinai provide me with access to health information in the manner described on this form. 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 the opportunity to modify to withdraw my request if I do not want to pay those fees.*

PRINTED NAME: JEFFREY  
SIGNATURE: [Signature]  
DATE: 01/09/2018

For a patient unable to sign on his/her own behalf, please indicate authority under which this release is signed:

Parent  Guardian  Other:

**DESTINATION**

Pickup  
 Mail (specify address/recipient if different from above)

RECIPIENT: DR. MOSKOWITZ  
ADDRESS: 1411 N. FLAGLER DR, SUITE 7100  
CITY: W. PALM BEACH STATE: FL ZIP CODE: 33401

**MOUNT SINAI PROCESSING NOTES**

Return completed form (with any applicable fee) to:

Mail: Medical Records  
Mount Sinai Radiology Associates  
1176 Fifth Avenue, MC Level  
Box 1235  
New York, NY 10029