



MOUNT SINAI
SCHOOL OF
MEDICINE

World Trade Center
Medical Monitoring and
Treatment Program
Data and Coordination Center

17 East 102nd Street
2nd Floor, West Tower
New York, NY 10029
Tel: 212-824-7332
Fax: 212-241-7235

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO MOUNT SINAI

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

Date of Birth: _____ Tel. No.: (_____) _____
Month/Day/Year

Address: _____
(Street) (City) (State) (Zip)

Please request/check all that apply:

I authorize (Physician's Name) _____,
(Address) _____
(Telephone) _____, (Fax) _____,

to disclose medical information about my:

___ Office Visits (diagnostic notes) on: _____
Date(s)*

___ Pathology/ Biopsy Reports: _____
Date(s)*

___ Lab Results: _____
Date(s)*

___ PET/CT scans/other imaging: _____
Date(s)*

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

___ Other (please specify) _____

*If unsure of dates, please provide approximate month/year.

Records to be disclosed HIV-related information. ___ do include X do not include
 Alcohol and Drug Abuse Records ___ do include X do not include
 Psychiatric Records ___ do include X do not include

Reason for Disclosure Patient Request Physician 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.

I understand that this authorization is valid for one year from this date or until _____ and may be revoked by me at any time except to the extent Mount Sinai has already taken action based on my authorization.

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV-related information, the recipient(s) is prohibited from redisplaying any HIV related information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437/(212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient Signature: _____

Date: _____

Personal Representative

Signature: _____

Print Name: _____

Authority: _____

Tel. No.: _____

Address: _____

Date: _____

(Personal Representative to sign only if patient is a minor or incompetent).

To request records or to revoke authorization send a written request to releasing provider.

To: Samara Solan, MD
The Mount Sinai School of Medicine
WTC Medical Monitoring and Treatment Program
Data and Coordination Center,
Box 1057
17 East 102nd Street, 2nd floor, West Tower,
New York, NY 10029