



PATIENT ACCESS REQUEST FOR MEDICAL INFORMATION

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

Unit Number: _____ DOB: _____ Tel. No. ____/____/____
 Month/Day/Year

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

Please request/check all that apply:

ACCESS REQUESTED on-site inspection record copy @ \$.75/page

<u>Records</u>	<u>Bill</u>	<u>Date(s) of Service</u>	<u>Document(s)</u>
<input type="checkbox"/> Entire Designated Record Set	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Inpatient Visit(s)	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> ED Visit(s)	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ambulatory Surgery	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Outpatient Clinic – Manhattan	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> AHC	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Dialysis	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> IMA	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Jack Martin	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> NRC	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> OB/GYN	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Pediatrics	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Psychiatry	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Radiation Oncology	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Specialty _____		_____	_____
<input type="checkbox"/> Outpatient Clinic Queens	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Family Health Associates	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Senior Health Center	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Industrial Health Center	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> FPA Practice/Provider: _____ _____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> X-ray Films/Reports	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Pathology Slides/Reports	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Other	<input type="checkbox"/>	_____	_____

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: _____
Signature

Personal Representative _____ PRINT NAME: _____
Signature

Authority: _____ Date: _____

Address: _____ Tel No. _____

Need By: _____ Reason: _____

Send completed form to the most appropriate area listed below:

θ Mount Sinai Hospital
Medical Records
One Gustave L. Levy Place – Box 1111
New York, N.Y. 10029

θ FPA Patient Rights Coordinator
One Gustave L. Levy Place – Box 1061
New York, NY 10029

θ Mount Sinai Hospital Queens
Medical Records
25-10 30th Avenue
Long Island City, NY 11102

θ Northshore Medical Group
Medical Records
Huntington, NY

θ 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