

MOUNT SINAI USE OF INFORMATION AUTHORIZATION

Dear Patient,

Like other major academic medical centers, Mount Sinai depends greatly upon the generosity of our patients to help us provide the finest in patient care, educate the next generation of physicians, and promote research and discovery of new treatments and cures.

Federal law now requires hospitals to obtain your written authorization prior to informing you of educational programs and philanthropic initiatives that support the work of your doctors. Your authorization below permits Mount Sinai doctors, development officers, trustees, and other staff to learn the name(s) of your health care provider(s) for the purpose of contacting you about educational and philanthropic efforts that may be of interest to you.

No other information about you or your medical treatment will be disclosed – that is strictly between you and your doctor. Maintaining patient confidentiality and ensuring your right to privacy has always been, and will always be, a priority at Mount Sinai.

We hope you will take a moment to read this authorization and sign below. If you have any questions, please call the Compliance Officer in the Mount Sinai Development Office at (212) 373-4967.

Thank you.

I authorize that the Mount Sinai Hospital and Mount Sinai School of Medicine (“Mount Sinai”) may disclose the name of my health care provider(s) to Mount Sinai development officers, and other staff, volunteers, and consultants and contractors assisting in fund raising efforts, for the purpose of contacting me about Mount Sinai educational efforts (e.g., lectures, informational newsletters) and fund raising opportunities. I understand that this authorization will expire five (5) years from the date of my signature below. I also understand that my health care treatment at Mount Sinai will not be affected in any way by my refusal or failure to sign this form. I further understand that this authorized information will not be released to any third party vendors for any purpose other than that expressed above. I may revoke this authorization at any time by writing to the Mount Sinai Development Office, One Gustave L. Levy Place, Box 1049, New York, New York 10029-6574. By signing below, I acknowledge that I have read and accept all of the above.

X _____
Signature of Patient
or Personal Representative/Guardian

X _____
Print Name of Patient
or Personal Representative/Guardian

X _____
Date

X _____
Address of Patient

If Applicable, Description of Authority of Personal Representative/Guardian

The patient, or personal representative/guardian, must be provided with a copy of this form after it has been signed.