# PATIENT ACCESS REQUEST FOR MEDICAL INFORMATION

## PLEASE PRINT PATIENT INFORMATION

| LAST NAME: | FIRST NAME: | MIDDLE: |
|---|---|---|
| Name at Time of Treatment (If different than above) | | |
| Date of Birth (MM/DD/YYYY): | Phone: | Email (optional): |
| Street Address: | City & State: | Zip Code: |

**LOCATION(S) OF SERVICE** (check only those where you received services):

- ☐ Mount Sinai Beth Israel
- ☐ Mount Sinai Queens
- ☐ Mount Sinai West (aka Roosevelt)
- ☐ Mount Sinai St. Luke's
- ☐ Mount Sinai Chelsea
- ☐ Mount Sinai Doctors Faculty Practice:
  - ☐ Long Island ☐ Manhattan/Queens ☐ Brooklyn ☐ Bronx/Westchester ☐ Staten Island
- ☐ Mount Sinai Hospital
- ☐ New York Eye and Ear Infirmary at Mount Sinai
- ☐ Mount Sinai Brooklyn (aka Kings Highway)
- ☐ Mount Sinai Union Square
- ☐ Other - Please Specify: ______________________________

## PLEASE FILL IN INFORMATION AND CHECK ALL BOXES THAT APPLY

| Records/Information Requested | Date(s) of Service | Location(s) of Service |
|---|---|---|
| ☐ Entire Medical Record | ________________ | ______________________________ |
| ☐ Inpatient Visit(s): | | |
| ☐ Discharge Summary | ________________ | ______________________________ |
| ☐ Operative Report | ________________ | ______________________________ |
| ☐ Ambulatory Surgery | ________________ | ______________________________ |
| ☐ Emergency Department (ER) | ________________ | ______________________________ |
| ☐ Outpatient Physician Office | | |
| ☐ Provider Name ________________ | ________________ | ______________________________ |
| ☐ Outpatient Clinic | | |
| ☐ Clinic Name ________________ | ________________ | ______________________________ |
| ☐ Designated Record Set | ________________ | ______________________________ |
| ☐ Test Results: | | |
| ☐ Cardiac Cath Reports ☐ Radiology Reports ☐ Pathology Reports | | ☐ Laboratory |
| ☐ Cardiac Cath Films ☐ Radiology Images ☐ Pathology Slides | | ______________________________ |
| ☐ Other________________ | ________________ | ______________________________ |

**Purpose of Request:** ☐ Self ☐ Continuing Treatment ☐ Benefits ☐ Other: ________________________

## PLEASE CHECK REQUESTED FORMAT/MODE OF DELIVERY

**PAPER:** ☐ MAIL ☐ PICKUP **DISC:** ☐ MAIL ☐ PICKUP ☐ ONSITE INSPECTION

**ELECTRONIC:** ☐ PDF/EMAIL: Email to send record to (REQUIRED): ________________________________

The Mount Sinai Health System responds to patient access requests in accordance with HIPAA and NYS laws. 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 requests for medical record copies are subject to reproduction fees allowed by laws and regulations, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

Signature of Patient or Personal Representative:____________________________________________Date:________________

*(Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf)*

Personal Representative Print Name:____________________________________________Relationship/Authority:____________

Address: ______________________________________________________Telephone Number: ____________________________

| SEND COMPLETE FORM TO THE MOST APPROPRIATE AREA LISTED BELOW | | |
|---|---|---|
| **Site** | **Address** | **Telephone Number** |
| The Mount Sinai Hospital | The Mount Sinai Hospital<br>HIM/Medical Records<br>One Gustave L. Levy Place, Box 1111<br>New York, NY 10029 | 212-241-7607 |
| Mount Sinai Queens | Mount Sinai Queens<br>HIM/Medical Records<br>25-10 30th Avenue<br>Long Island City, NY 11102 | 718-808-7683 |
| Mount Sinai Beth Israel | Mount Sinai Beth Israel<br>Health Information Management<br>First Avenue at 16th Street<br>New York, NY 10003 | 212-420-2665<br>x-0 |
| Mount Sinai Brooklyn | Mount Sinai Brooklyn<br>Health Information Management<br>3201 Kings Highway<br>Brooklyn, NY 11234 | 718-951-2806 |
| Mount Sinai Doctors<br>Faculty Practice | Make requests directly to the practice –<br>Call practice to obtain address information<br>OR<br>Mount Sinai Doctors Faculty Practice – Medical Records<br>1 Gustave L. Levy Place, Box 1111<br>New York, NY 10029 | Individual Practice |
| Mount Sinai Union Square | Mount Sinai Beth Israel<br>Health Information Management<br>First Avenue at 16th Street<br>New York, NY 10003<br>Attn: Outpatient Team | 212-844-5275 |
| Mount Sinai St. Luke's | Mount Sinai St. Luke's<br>Health Information Management<br>1090 Amsterdam Avenue<br>13th floor, Suite B<br>New, NY 10025 | 212-523-3265 |
| Mount Sinai West | Mount Sinai West<br>Health Information Management<br>1000 Tenth Avenue<br>New York, NY 10019 | 212-523-6623 |
| Mount Sinai Chelsea | Mount Sinai Downtown Chelsea<br>Health Information Management<br>325 West 15th Street<br>New York, New York 10011 | 212-604-6045 |
| New York Eye and Ear Infirmary | New York Eye and Ear Infirmary<br>Medical Records<br>310 East 14th Street<br>New York, NY 10003 | 212-979-4352 |