Mount Sinai
MEDICAL CENTER

Authorization to Disclose Protected Health Information

Patient Name ______________________________ Medical Record Number_______________

Date of Birth _________ Social Security Number __________ Address _________________________
Phone Number ________________

1. **I authorize the use or disclosure of the above named individual's health information as described below.**
2. The following individual or organization is authorized to make the disclosure:

   Mount Sinai Medical Center___ Other Facility/Provider (Specify) _______________________________

   Address ____
3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
   - ___Face Sheet
   - ___History and Physical Exam ___Admission Note ___Discharge Summary
   - ___Imaging / x-ray reports (date) ___
   - ___Laboratory results (date) ___
   - ___Consultation reports by (Doctors names)____________________________
   - ___Progress Notes ___Physician Orders
   - ___Medication Lists ___ Operative / Procedure report
   - ___Cardiovascular Studies ___ Nursing Notes
   - ___Emergency Room record ___ Other (Specify)____________________________________
   - ___Entire Record

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:
   ____
   Address: ____
   For the purpose of ____

6. I understand that I have a right to revoke this authorization at any time except to the extent that action has been taken in reliance upon it. I understand that if I revoke this authorization I must do so in writing and present my revocation to the Health Information Management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date, event, or condition: ____. If I fail to specify an expiration date, event of condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in **CFR 164.524**. I may also request a copy of this form. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless, for complying with the "Authorization to Disclose Health Information." If I have questions about disclosure or my health information, I can contact the Health Information Management Department at 305-674-2320.

_______________________________________ _______________________________
Signature of Patient or Legal Representative Date

_______________________________________ _______________________________
If Signed by Legal Representative, Relationship to patient Signature of Witness