Mount Sinai Medical Center
Miami Beach, Florida

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information *(Please Print)*

First Name | Middle Initial | Last Name

Street Address | City | State | Zip

Date of Birth (MM/DD/YYYY) | Phone | Email *(optional)*

I authorize the use or disclosure of the above name individual's health information as described below.
Indicate the type of information to be disclosed:

Date(s) Requested: _____/_____/_____ through _____/_____/_____

- ☐ Discharge Summary
- ☐ Emergency Department Records
- ☐ Other (Consultations, Progress Notes)
- ☐ Entire Record
- ☐ Operative/Procedure Reports
- ☐ Test Results (X-Rays, Lab/Pathology Results, Cardiovascular Studies)
  Please Specify: _____
- ☐ Physician Practice Records
  Please Specify Physician's Name: _____

Format & Delivery Method Requested:

Paper Copy: ☐ Mail ☐ In Person pick up ☐ Email: Provide Email to send record to (Required):
_____

CD Medical Record: ☐ Mail ☐ In Person pick up
CD Radiology/Imaging Dept: ☐ Mail ☐ In Person pick up

This information may be disclosed to and used by the following individual or organization: *(Please fill in below)*

Name/Institution: _____

Address: _____

For the purpose of _____

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 behavior or mental health services and treatment for alcohol and drug use.
_____ *(Initials)*

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 consent 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.
_____ *(Initials)*

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.
_____ *(Initials)*

_____ Name of Patient or Legal Representative *(Please Print)*

_____ Relationship *(Please Print)*

_____ Signature of Patient or Legal Representative

_____ Date

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