Mount Sinai

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

(check only those where you received services):

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 Images Pathology Slides		_____
Other_____	_____	_____

Self Continuing Treatment Benefits

MAIL PICKUP MAIL PICKUP ONSITE INSPECTION

PDF/EMAIL: Email to send record to (REQUIRED): _____