Mount Sinai

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 Hospital
New York Eye and Ear Infirmary at Mount Sinai

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 / Cardiac Cath Films		
Radiology Reports / Radiology Images		
Pathology Reports / Pathology Slides		
Laboratory		_____
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): _____