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Mount Sinai Health System HIPAA

Mount Sinai

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: _____

The Mount Sinai Hospital	The Mount Sinai Hospital HIM/Medical Records One Gustave L. Levy Place, Box 1111 New York, NY 10029	212-241-7607
Mount Sinai Queens	Mount Sinai Queens HIM/Medical Records 25-	