Mount Sinai

# PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY

**PLEASE PRINT PATIENT INFORMATION**

| **LAST NAME:** | **FIRST NAME:** | **MIDDLE:** |
|---|---|---|
| Name at Time of Treatment (If di□erent 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 Hospital

Mount Sinai Queens

New Y 51 B(t0.mFK57 B61 Tm(Phone:)TjETEMC /Span <Lang (en-US)/MC

**PLEASE FILL IN INFORMATION AND CHECK ALL BOXES THAT APPLY**

Mount Sinai

**Authorizing release of records to:**

Healthcare Provider

Mount
Sinai

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