PATIENT AUTHORIZATION to ACCESS MOUNT SINAI MEDICAL RECORDS via CARELINK

Patient's Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Tel. No.:___/_____/_____
Month/Day/Year

Address: _____
(Street) (City) (State) (Zip Code)

I authorize my provider **Central Park Endocrinology, PC** to access my Mount Sinai medical records through CareLink

I understand my HIV, Alcohol and Drug Use, Psychiatric/Mental Health and Genetic information may be included.

I understand that this authorization is valid as long as I am under the care of the above noted healthcare provider and may be revoked by me at any time except to the extent that action has been taken based on my authorization.

Central Park Endocrinology, PC will not condition treatment or payment on whether you sign this authorization.

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437/(212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be redisclosed if the recipient(s)as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Print Name: _____

Authority: _____ Tel. No: _____

Address: _____ Date: _____

{Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf}

To request records or to revoke authorization, send a written request to:

Central Park Endocrinology, PC
115 Central Park West, Suite 14, NY, NY. 10023
Fax: 212-873-9311