Icahn School of Medicine at Mount Sinai

Student Health Center

Mount Sinai
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574

Tel: (212) 241-6023
Fax: (212) 241-8008
studenthealth@mssm.edu

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

STUDENT INFORMATION

Student Name (First, Middle Initial , Last):	**Date of Birth:**	**Telephone Number:** ☐ HOME ☐ CELL

Address: _____

Address *City* *State* *Zip Code*

AUTHORIZATION FOR RELEASE

I authorize the Student Health Center at the Icahn School of Medicine at Mount Sinai to release medical information about my (please check all that apply):

☐ Immunizations
☐ Titers
☐ Chest xray
☐ Other (specify): _____

_____

Records should be released to:

☐ The Mount Sinai Medical Center
☐ Other (please specify): _____

_____

_____

PATIENT SIGNATURE

I understand that this authorization is valid for one (1) year from this date and may be revoked by me at any time.

_____ _____

Student Signature Date