Mount Sinai Morningside

Mount Sinai West

AMBULATORY PATIENT NOTIFICATION RECORD

I acknowledge that I have been given the following Notices as required by State and Federal regulations:

- New York State Patients' Bill of Rights
- Patient's Bill of Rights
- Mount Sinai Morningside and Mount Sinai West Patient Information on Pain Management
- New York State Health Care Proxy
- Mount Sinai Morningside and Mount Sinai West Summary of Policy On Advance Directives
- Mount Sinai Health System Notice of Privacy Practices

And I consent to share my health information for payment, treatment and hospital operations purposes.

_____ _____ _____

Patient/Parent/Personal Representative Signature | Date | Time

_____

Representative Relations to Patient

Patient: □ Unable to sign Explain

_____

□ Refuses to Sign

_____ _____

Print Name | Title

_____ _____ _____

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