Student Clinic

The Mount Sinai Hospital

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Ambulatory Accounts

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From: Mike Green, Eva Hasa, & David Thomas M.D. M.S.
Student Clinic

Date: _____

Subject: AUTHORIZATION OF FUNDS FOR STUDENT CLINIC VISIT

I hereby authorize that fund from THE EAST HARLEM HEALTH OUTREACH PARTNERSHIP FUND # 0285-0600-4530 be transferred to PATIENT FINANCIAL SERVICES #
01-01-0900-1240 for the Student Clinic patient listed below:

PATIENT NAME:_____

PATIENT PHONE#:_____

MEDICAL RECORD#:_____

DATE OF BIRTH:_____

AMOUNT AUTHORIZED FOR TRANSFER: _____

_____
Mike Green, Eva Hasa, David Thomas
Authorized Signatory

Cc: Kelinda Rolon Fax: 212-731-3418