

Student Clinic

The Mount Sinai Hospital

One Gustave L. Levy Place
New York, NY 10029-

6574

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TO: Aubrey Cookhorne/ Justine Rivera
Ambulatory Accounts

Fax#: (212) 410-6679

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:

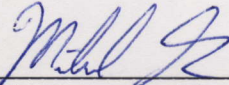
PATIENT NAME: _____

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