Stony Brook Medicine

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (name of provider) **Stony Brook University Hospital**

(2) To disclose the following information from the health records of:

Patient name: _____ Date of birth: _____

Address: _____ Telephone:_____

_____ Medical Record Number: _____
(office use only)

(3) Dates of Treatment:_____

Requested Information:

☐ Abstract (subset of records)	☐ Emergency Record	☐ Autopsy Report
☐ Discharge Summary	☐ Laboratory Testing	☐ Pathology Report
☐ Operative Report	☐ Consults	☐ Endoscopy/Colonoscopy
☐ Radiology (X-Ray, MRI,etc.)	☐ Cardiac Testing	☐ Complete Record
☐ Cardiac CD		

Other (please specify) _____

I understand that this may include **sensitive information** relating to:

Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
Behavioral health services/psychiatric care.
Treatment for alcohol and/or drug abuse.

At the request of the patient, this information is to be released to: _____

_____

_____

For the purpose of _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date signed. I also understand I may refuse to sign this form and that my health care and payment will not be affected.

The facility, its employees, officers, and physicians are hereby released form any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I may request a copy of this form after signing.

Signed: _____ Date:_____
(Patient)

(This form has been completed before signing)

_____ Date: _____
(Legal representative)

(Relationship to patient, description of authority)

_____ Date: _____
(Signature of witness)

(Relationship to patient)

Note: Release of all confidential information is governed by State and Federal and HIPAA Regulations