Stony Brook Medicine

PATIENT REQUEST FOR DISCLOSURE

I hereby authorize ________________________________ to disclose the following information from my health record

Patient name: ____ Date of birth: ________________________

Address: ____ Telephone: __________________________

____ Medical Record Number: _____________

Dates of Treatment being requested: ____

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.

This information is to be released to: ____

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Please send by the following method:

☐ Printed copy @ 75 cents per page ☐ CD @ $6.50 ☐ Electronic download @ $6.50

☐ e-Mail to ____________________________________ @ $6.50
(print very clearly)

Please note: e-mail is not a secure method of transmission of your health information. Stony Brook Medicine is not responsible for the privacy of information e-mailed at your request.

Signed: ____ Date: _____________
(Patient) or (Parent/Legal Guardian)

____ Date: _____________
Health Care Agent – Only if the patient lacks capacity to sign for his/her self

MR2N585 (7/17)