Stony Brook Children's

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

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