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)
- ☐ 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: _____

_____

_____

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