PP2C700

Stony Brook Medicine

Stony Brook, NY 11794

AMBULATORY CARE
AUTHORIZATION TO DISCUSS PHI WITH A DESIGNEE

Patient's Name: _____ Date of Birth: _____
(please print clearly) (please print clearly)

By signing below I hereby give permission to _____
(Name of Provider, UFPC Practice)

to discuss with the following individuals information related to health care services I receive at the above named physician's office/physician practice (UFPC). I agree this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information), prescription refill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this **does not** include the ability for the individuals noted below to authorize the disclosure of my protected health information (PHI) to a third party or to request on my behalf a copy of my health information. I agree this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice (UFPC) noted above.

1. Name of Individual: _____ Relationship to Patient: _____

   Phone Number: _____

2. Name of Individual: _____ Relationship to Patient: _____

   Phone Number: _____

3. Name of Individual: _____ Relationship to Patient: _____

   Phone Number: _____

☐ Check here if you do not wish for us to communicate with anybody but you about your care.

Signature of Patient: X_____

Time: _____ Date: _____

FOR OFFICE USE ONLY:

Patient's MRN: _____

Date Received: _____

English: PP2C700 (5/23)
Spanish: PP2S700 (5/23)