Stony Brook Medicine

School of Medicine
Department of Psychiatry
Stony Brook, NY 11794-8790

Date: _______________

Dear Dr. ___________________________________,

Your patient ____, date of birth _______________, was assessed by Dr. ___________________________________ of Stony Brook Psychiatric Associates, UFPC, on _______________.

The initial diagnosis is ____
____
____
____
____.

Please forward copy of this patient's most recent physical and lab results obtained by you to my attention at:

Stony Brook Psychiatric Associates
Adult Psychiatry Outpatient Department
Stony Brook University
Putnam Hall, South Campus
Stony Brook, NY 11794-8790

Please feel free to contact me at (631) 632-9510 should you have questions regarding this request.

Sincerely,

____

RELEASE AUTHORIZATION / DENIAL

I _____________________________________, authorize Stony Brook Psychiatric Associates to submit this request to Dr. _____________________________________, on this ______ date of _______________, 20______.

I _____________________________________, **DO NOT** authorize submission of this request.