

267 East Main Street, Building C Smithtown, New York 11787 Phone 631-257-5290 / Fax 631-257-5295 ALLINCLUSIVEPRIMARYCARE.com

Date

Patient Name: Date:				LEASE OF MEDICAL INFORMA	
Date of Birth: Phone: SSN:					
Name			-		
Name Relationship:	Date of Birth:	Phone:		SSN:	
AND/OR FROM DOCTOR: TO: Name Name Name Street Address Street Address City/State/Zip What records should be released? What records should be released? From To To Are you leaving the Practice? YES NO If the requested portion of the record contains information concerning drug, psychiatric or alcohol treatment or contains HIV related information you must specifically consent to release of such information by initialing both of the following: Please Initial I understand that if my records contain information information; such information will be released pursuant to this consent form. I understand that if my records contain confidential HIV related information will be released pursuant to this consent form. Confidential HIV related information is any information in which indicate that a persona has been potentially exposed to HIV. I understand that if my records contain confidential HIV related information will be released pursuant to this consent form. Confidential HIV related information is any information information will be released pursuant to this consent form. Confidential HIV related information is any information information information will be released pursuant to this consent form. Confidential HIV related information is any information information in which indicate that a persona has been potentially exposed to HIV. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation. This consent will expire in one year.	I hereby authorize Stony Brook	к Community M	ledical, PC to	release my medical records to	
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Street Address Street Address City/State/Zip What records should be released? What date range should be released? From To			AND/OR		
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written authorization to do so.	•	ot authorized to dis	sclose this info	rmation from this patient's medical reco	rd to any other person or facility without

Witness's Signature

Date

Patient/Guardian Signature

^{**}SHOULD BE NOTARIZED IF PATIENT IS NOT PRESENTING FORM IN PERSON (i.e. mailing it or faxing it back)**