

Stony Brook Psychiatric Associates, P.C. Psychiatry Outpatient Services Authorization for Release of Protected Health Information

Patient Name:	Date of Birth:
discussion of information related to the health care sthat this does <u>not</u> include allowing the individuals be or to request a copy of my health information. I agreequest to the physician practice noted above. Significant processing the process of the physician practice of the physician practice noted above.	to release my information from the person or persons below. This information will be limited to services I receive at the above named physician's office/physician practice. I agree allow to authorize the disclosure of my protected health information to a third party see that this authorization will remain active until I revoke it by submitting a written gning this authorization is voluntary. I understand that generally my treatment, it benefits will not be conditional upon my authorization of this disclosure. However, some circumstances if I do not sign this consent.
Name of Individual:	Relationship to Patient:
	Contact Information:
Name of Individual:	Relationship to Patient:
	Contact Information:
Name of Individual:	Relationship to Patient:
	Contact Information:
Name of Individual:	Relationship to Patient:
	Contact Information:
Name of Individual:	Relationship to Patient:
	Contact Information:
Signature of Patient:	Date:
Witness Statement: I have witnessed the execution available to the patient and/or the patient's authorize	of this authorization and state that a copy of the signed authorization was made zed representative at their request.
Witness Printed Name:	
Signature of Witness:	Date: