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)	☐ Emergency Record	☐ Autopsy Report
☐ Discharge Summary	☐ Laboratory Testing	☐ Pathology Report
☐ Operative Report	☐ Consults	☐ Endoscopy/Colonoscopy
☐ Radiology (X-Ray, MRI,etc.)	☐ Cardiac Testing	☐ Complete Record
☐ Cardiac CD		

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