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
Child and Adolescent Psychiatry Outpatient Department
Stony Brook University
Putnam Hall, South Campus
Stony Brook, NY 11794-8790

Please feel free to contact me at (631) 632-8850 should you have questions regarding this request.

Sincerely,

_____

RELEASE AUTHORIZATION / DENIAL

I _____, the parent/guardian of _____, authorize Stony Brook Psychiatric Associates to submit this request to Dr. _____, on this _____ date of _____, 20_____.

I _____, the parent/guardian of _____, **DO NOT** authorize submission of this request.

Signature: _____ Date: _____