



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

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