Stony Brook Medicine
Stony Brook Pediatrics of Sayville

285 W. Main Street
Suite 104
Sayville, NY 11782
TEL (631) 563-8190
FAX (631) 563-8194

Patient Name: _____ Date of Birth _____

Address: _____ Phone: _____

I authorize release of my medical record to:

Physician: _____

Address: _____

Phone/Fax: _____

Please send my medical record from:

Stony Brook Pediatrics of Sayville
285 W. Main Street, Ste 104
Sayville, NY 11782

Release all medical information including recent H&P, Labs, consults, last three visits:

Reason: _____ Change of Insurance _____ Transfer of Care _____ Personal File

_____ Moving out of area _____ Legal

I authorize the release of all information indicated.

_____

Signature of patient, parent, guardian, conservator, or patient representative (please circle) Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.