Stony Brook Medicine

Stony Brook Extended Care
A LOCATION OF STONY BROOK INTERNIST
UNIVERSITY ASSOCIATES IN OBSTETRICS & GYNECOLOGY

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date: _____

Address: _____ City/State/Zip:_____

Date of Birth: _____ Phone: _____ SSN: _____

I hereby authorize Stony Brook Community Medical, PC to release my medical records to

Name: _____ Relationship: _____

_____ _____

_____ _____

AND/OR

FROM DOCTOR: TO:

_____ _____
Name Name

_____ _____
Street Address Street Address

_____ _____
City/State/Zip City/State/Zip

What records should be released? _____

What date range should be released? From _____ To _____

Are you leaving the Practice? YES NO _____

If the requested portion of the record contains information concerning drug, psychiatric or alcohol treatment or contains HIV related information you must specifically consent to the release of such information by initialing both of the following:

Please Initial

_____ I understand that if my records contain information concerning drug, alcohol treatment, or psychiatric treatment such information will be released pursuant to this consent form.

_____ I understand that if my records contain confidential HIV related information; such information will be released pursuant to this consent form. Confidential HIV related information is any information indicating that a HIV test was done, HIV virus is present, HIV related illness or AIDS, or any other information in which indicate that a persona has been potentially exposed to HIV.

_____ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

This consent will expire in one year.

The recipient of this information is not authorized to disclose this information from this patient's medical record to any other person or facility without written authorization to do so.

_____ _____
Patient/Guardian Signature Date Witness's Signature Date

SHOULD BE NOTARIZED IF PATIENT IS NOT PRESENTING FORM IN PERSON (i.e. mailing it or faxing it back)