Patient Name:
Date of Birth:
MRN: Office Use Only

Stony Brook Psychiatric Associates, P.C.
Psychiatry Outpatient Services
Authorization for Release of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

By signing below, I hereby authorize _____ to release my health care information to and obtain health care information from the person or persons below. This information will be limited to discussion of information related to the health care services I receive at the above named physician's office/physician practice. I agree that this does not include allowing the individuals below to authorize the disclosure of my protected health information to a third party or to request a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting a written request to the physician practice noted above. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Name of Individual: _____ **Relationship to Patient:** _____

Contact Information: _____

Name of Individual: _____ **Relationship to Patient:** _____

Contact Information: _____

Name of Individual: _____ **Relationship to Patient:** _____

Contact Information: _____

Name of Individual: _____ **Relationship to Patient:** _____

Contact Information: _____

Name of Individual: _____ **Relationship to Patient:** _____

Contact Information: _____

Signature of Patient: _____ **Date:** _____

Witness Statement: I have witnessed the execution of this authorization and state that a copy of the signed authorization was made available to the patient and/or the patient's authorized representative at their request.

Witness Printed Name: _____

Signature of Witness: _____ **Date:** _____