



# Stony Brook Southampton Hospital

240 Meeting House Lane Southampton, NY 11968

PATIENT LABEL

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Stony Brook Southampton Hospital to disclose the following information from my health record

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_ Medical Record Number: \_\_\_\_\_  
(Office use only)

Date(s) of Treatment being requested: \_\_\_\_\_

### Requested Information:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abstract (subset of records) | <input type="checkbox"/> Consults              | <input type="checkbox"/> Operative Report                                      |
| <input type="checkbox"/> Autopsy Report               | <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Pathology Report                                      |
| <input type="checkbox"/> Cardiac CD                   | <input type="checkbox"/> Emergency Record      | <input type="checkbox"/> Radiology Image CD                                    |
| <input type="checkbox"/> Cardiac Testing              | <input type="checkbox"/> Endoscopy/Colonoscopy | <input type="checkbox"/> Radiology (X-Ray, MRI, etc.)<br>(written report only) |
|   | <input type="checkbox"/> Laboratory Testing    | <input type="checkbox"/> 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 substance use disorder.

This information is to be released to: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

The records can be received by the following:

- Printed copy       CD
- Electronic download / E-Mail to \_\_\_\_\_  
(print very clearly)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient) or (Parent/Legal Guardian)

\_\_\_\_\_  
(Legal representative)      (Relationship to patient,  
Description of authority)      Date: \_\_\_\_\_

Any disclosure of substance use disorder patient records is governed by Federal law (see 42 CFR Part 2), and all disclosures of such records shall be accompanied by the following written statement:

*This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any substance use disorder patient.*