AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (name of provider):

Stony Brook Surgical Associates / Stony Brook University Department of Surgery

(2) To disclose the following information from the health records of:

Patient name: ______________________________

Date of birth: ______________________________ Telephone: ______________________________

Address: ______________________________

(3) Information to be disclosed:

☒ **General summary of care**
□ History & physical examination
□ Consultation reports
□ X-ray(s)
□ Surgery procedure done on (date:) ____________
□ Progress notes
□ Laboratory tests
□ Complete health record(s)

Other (please specify): ______________________________

(5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date signed. I also understand I may refuse to sign this form, and that my healthcare and payment will not be affected. Initials__________________

(6) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
Initials__________________

(7) I may request a copy of this form after signing. Initials__________________

Signed: ______________________________ Date: ______________
(Patient) This form has been completed before signing

____
(Legal representative) (Relationship to patient)

______________________________ Date: ______________
(Signature of witness)

Note: Release of all confidential information is governed by State and Federal and HIPAA Regulations