Stony Brook University

STUDENT HEALTH SERVICE
FAX 631-632-6936

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the University at Stony Brook Student Health Service to disclose the following information from the health records of:

Patient Name _____ Date of birth _____
Address _____
_____ Telephone ( )_____
Patient ID number _____
covering the period(s) of health care
FROM: (date) _____ **TO:** (date)_____

INFORMATION TO BE RELEASED:: ***(PLEASE INITIAL)***

____complete health record(s)
____history & physical examination
____ consultation reports
____ X-ray reports
____other (please specify)_____
____Alcohol and Drug Abuse Records
____Immunization Records
____Progress Notes
____Laboratory tests
____Photographs, videotapes
____Records Pertaining to STD's
____HIV tests(Separate Authorization Req.)

INFORMATION TO BE RELEASED TO:

Name _____
Address_____
City_____ State_____ ZIP_____
Telephone_____ FAX_____

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 on the following date, event, condition, or one year from the date of the request if no date is specified:
Expiration Date:_____.
The University Student Health Service, 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

_____ _____
Patient Signature Date

_____ _____ _____
(Signature Legal representative) (Relationship to patient) Date

_____ _____
(Signature of witness) Date

**** FOR RELEASES FAXED/MAILED TO THE STUDENT HEALTH SERVICE PLEASE INCLUDE A COPY OF SIGNATURE ID****

_____**F**

OR OFFICIAL USE

REVIEWED BY_____
COMPLETED BY_____ ID CHECKED ____ DATE _____

CIRCLE ONE: FAXED MAILED IN PERSON