



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) | _____ Immunization Records/ Health Form |
| _____ Progress Note(s) Dates _____ | _____ Laboratory tests –Dates _____ |
| _____ Radiology report(s) | _____ Photographs, videotapes |
| _____ Other (please specify) _____ | _____ Records Pertaining to STD's |
| _____ Alcohol and Drug Abuse Records | _____ 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****

FOR OFFICIAL USE

REVIEWED BY _____
COMPLETED BY _____ ID CHECKED _____ DATE _____

CIRCLE ONE: FAXED MAILED IN PERSON