



Stony Brook  
Medicine

### AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (name of provider) **Stony Brook University Hospital**

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

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

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

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

(3) Dates of Treatment: \_\_\_\_\_

**Requested Information:**

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

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 drug abuse.

At the request of the patient, this information is to be released to: Hoosier Services Inc  
18032 Lemon Dr, Ste C-618  
Yorba Linda, CA 92886

For the purpose of Life Insurance purpose

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 health care and payment will not be affected.

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.

I may request a copy of this form after signing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient) (This form has been completed before signing)

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

\_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of witness) (Relationship to patient)