Stony Brook Medicine

Ambulatory Care
Authorization to Discuss PHI with a Designee

Patient's Name: _____ Date of Birth: _____
(Please Print Clearly) (Please Print Clearly)

By signing below I hereby give permission to _____
(Name of Physician, Physician Practice or Service Practice)

to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this **does not** include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

_____
Signature of Patient

_____ _____
Date Time

For Office Use Only

Patient's MRN _____

Date received: _____

This form is for office use only. Place in the correspondence section of the medical record. Not for release or disclosure.