



MR2N158

STONY BROOK
UNIVERSITY
MEDICAL CENTER

UNIVERSITY HOSPITAL
HEALTH SCIENCES CENTER
STATE UNIVERSITY OF NEW YORK
AT STONY BROOK
STONY BROOK, NEW YORK 11794

REQUEST FOR MEDICAL INFORMATION

TO: _____

Date: _____ Medical Record Number: _____

Patient: _____			Date of Birth
(Last name)	(First name)	(Middle initial)	
(Home Address)			Telephone Number:

The above named patient is now being treated at this hospital under the care of

PHYSICIAN & DEPARTMENT

The patient's history reveals he/she was treated at your facility on or about _____

The above named physician has requested medical information regarding this previous treatment. Below is a properly signed authorization to release copies of your medical records to this institution.

Thank you for your cooperation.

Sincerely,

Medical Records Department, 7131

I, _____, hereby authorize release to the University Hospital, Health Sciences Center, SUNY at Stony Brook, copies of my medical records compiled during my confinement from _____ to _____

Date: _____ Signature of Patient: _____

Witness: _____ Signature of Other: _____
(state relationship)

NOTE: xeroxed or photocopies of this authorization may be considered as originals

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