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### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release the healthcare information of the patient named above via fax or postal to:

Name: Stony Brook Health Outreach and Medical Education C/O Dr. Jedan Phillips

Address: Office of Student Affairs, L4 Health Sciences Center, Rm 147

City: Stony Brook State: NY Zip Code: 11794-8436

Phone: (631) 235-5281 Fax: (877) 322-6722

This request and authorization applies to:

Healthcare information relating to the following treatments, conditions, or dates: \_\_\_\_\_  
\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Yes  No I understand that I have the right to voluntarily retrieve my records, and I waive my right to hold the above mentioned health care provider accountable for the transmission of my records.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.