AUTHORIZATION FOR RELEASE OF LABORATORY RESULTS

FOR: STONY BROOK MEDICAL CENTER
LYME DISEASE LABORATORY
101 NICOLLS RD.
LEVEL 3, ROOM 508
STONY BROOK, NY 11794
PHONE: 631-444-3824 FAX: 631-444-7526

I hereby authorize and request you to release my laboratory results in your possession from (Date of service):

PLEASE FILL IN ALL LINES MARKED WITH AN "X:" FOR THE PHYSICIAN AND PATIENT INFORMATION BELOW AND FAX TO: 631-444-7526 OR MAIL TO THE ADDRESS ABOVE.

LAB USE ONLY: **TYPE OF SPECIMEN(S):** **ACCESSION #, LYME #, MRN:**

Physician's Name **X:**
Physician's Address **X:**
X:
Physician's Phone #: **X:**
Physician's Fax #: **X:**

Patient's Name **X:**
Patient's Address **X:**
X:
Patient's Phone # **X:**
Patient's Date of Birth **X:**

Patient's Signature **X:**
Date **X:**
COMMENTS: