Stony Brook Eastern Long Island Hospital

PLACE PATIENT STICKER HERE

Patient or Representative Authorization Form

I would like to have access to my patient records in the patient portal as well as all other functionality of the YourCareCommunity Patient Portal.

PATIENT NAME (PRINT) _____ DOB _____

PATIENT SIGNATURE _____ DATE _____

EMAIL ADDRESS _____

EMAIL ADDRESS (verification) _____

I hereby give permission to _____ to have access to my patient records in the patient portal as well as all other functionality of the YourCareCommunity Patient Portal.

PATIENT SIGNATURE _____ DOB _____ DATE _____

REPRESENTATIVE NAME (PRINT) _____

REPRESENTATIVE EMAIL ADDRESS _____

REPRESENTATIVE EMAIL ADDRESS (verification) _____

- ⬭ Patient declines at this time
- ⬭ Patient was unable to agree at this time

***Federal regulation (42, 45 CFR Part 2) prohibits redisclosure without specific written consent of the person to whom it pertains.**

Revised: 06/28/2019