Stony Brook
Eastern Long Island Hospital
201 Manor Place Greenport, NY 11944

PATIENT LABEL

SBELIH Patient Portal Authorization Form

To be completed by Admitting Department upon admission for all new patients
Patients can also submit completed forms to: Fax: 631-477-8316 or
email: elih_medicalrecords@stonybrookmedicine.edu

Patient Access Authorization

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): _____

Patient Email Address: _____

Patient Email Address (Verification): _____

_____ _____ _____
Patient Signature **DOB** **Date**

Patient Representative Access Authorization*

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

Representative Name: _____ **Representative DOB:** _____

Representative Primary Phone #: _____

Representative Email Address: _____

Representative Email Address (Verification): _____

_____ _____ _____
Patient Signature **DOB** **Date**

☐ Patient declines access to Patient Portal at this time
☐ Patient was unable to agree to Patient Portal at this time

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