**Southeastern CT Medical Associates, PC**

447 Montauk Avenue, New London, CT 860-447-1426
123 Elm Street, Suite 500/600, Old Saybrook, CT 860-388-0322

Patient Name: _____ DOB: _____

# Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below.

I authorize/allow Southeastern CT Medical Associates, PC to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. I authorize the release of my medical and billing information with the understanding that they may include information regarding the following conditions: alcohol or drug abuse, psychological or psychiatric conditions, developmental disabilities, HIV, AIDS, sexually transmitted diseases, pregnancy, or other sensitive information. I understand that I may revoke this authorization in writing at any time except to the extent that SECTMA has already taken action in reliance on the authorization.

Patient Signature: _____ Date:_____