Southeastern CT Medical Associates, PC 447 Montauk Avenue, New London, CT 06320
123 Elm Street, Suites 500/600, Old Saybrook, CT 06475

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____
to release information from my medical records to:

Name: _____

Address: _____

_____

I request that the information to be used or disclosed consist of the following from the previous three years: progress notes, prescription data, immunizations, laboratory test results, consults, hospital notes, imaging and/or stress test results. *(If this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes).*

[ ] I specifically authorize that any sensitive information regarding HIV/AIDS, substance abuse (alcoholism or drug abuse), and/or mental health may be used by or disclosed to the above referenced recipients.

[ ] I do not authorize the release of HIV/AIDS, substance abuse, and/or mental health information.

This request is for the following reason:

[ ] Second Opinion [ ] Relocating [ ] Dissatisfied/Reason: _____
[ ] Insurance Change [ ] Changing Doctors [ ] Other: _____

All records of treatment are the legal property of Southeastern Connecticut Medical Associates, P.C. I understand that I will be responsible for an administrative fee associated with the copying of my records.
(Less than 25 pages = $10.00, More than 25 pages = $20.00)

I understand that the disclosed information may be re-disclosed in accordance with the law and may no longer be protected by the federal privacy standards. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by federal privacy standards. However, other state and federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

INDIVIDUAL'S RIGHT RELATING TO THIS AUTHORIZATION:
I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that SECTMA may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying SECTMA in writing of my revocation. I am aware that my revocation will not be effective as to uses and/or disclosures of the health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until _____. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Signature Date

_____ _____
Print Date of Birth