

**OLD GREENWICH MEDICAL GROUP**

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**Authorization for Release of Information to Family Members**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Many of our patients allow family members such as their spouse, parents or others to call and 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 information to family members indicated below.

I authorize **Old Greenwich Medical Group** 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 I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_