Paul H. Deutsch M.D., R.Ph., LLC

86 New London Turnpike
Norwich, CT 06360

Phone: 860 889-6967

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Section A: Must be completed for all authorizations
I hereby authorize the use or disclosure of my protected health information as described below. I understand this authorization is voluntary. I understand that if the organization to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Person/Organization providing the information:

_____

_____

_____

Person/Organization receiving the information:

PAUL H. DEUTSCH M.D., R.PH., LLC

86 NEW LONDON TURNPIKE

NORWICH, CT 06360 Fax: 860-885-1033

Description of information to be used or disclosed, including date(s). Check all that apply.

__ The patient's entire medical record (*this requires an explanation why the entire record may be disclosed.*)

__ Medical Data/Information as related to:

__ Specific condition (s): _____

__ Specific profession services (s): _____

__ Other: _____

Specific purpose of the information (including dates):

_____

_____

Section B: Must be completed only if specific information listed below is requested
The type of information listed below CANNOT BE USED OR DISCLOSED WITHOUT MY SPECIFIC CONSENT AND KNOWLEDGE. Therefore, I have INITIALED (any other mark not acceptable) before each type of record that I authorize you to use or disclose.

__ Alcohol and/or Drug Abuse Treatment Records

__ Mental Health Treatment Records

__ AIDS, ARC or HIV Testing Records

Section C: Must be completed for all authorizations
The patient or the patient's representative must read and initial the following statements:

_____ I understand that this authorization will expire on ___/___/___ (dd/mm/yr). Unspecified request dates will expire one year from signature.

_____ I understand that I may revoke this authorization at any time by notifying the provider organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

_____ I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

Revised June 19, 2014

_____ I understand that I may see and copy the information described on the form if I ask for it, and that I get a copy of this form after I sign it.

_____ I understand that Paul H. Deutsch., R.Ph., LLC may receive compensation for the uses and disclosure that I have authorized.

_____ _____

Signature of patient or patient representative (Form MUST be completed before signing) *Date*

_____

Printed name of patient representative

_____

Relationship to patient

*****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*****

FOR OFFICE USE ONLY:

Authorization added to patient's medical record on: _____.

Authorization verified by _____ on _____.

REDISCLOSURE IS PROHIBITED

This information has been disclosed to you from records protected by Federal law, 42-CFR Part II and State law concerning confidentiality. The Federal rules and State law prohibit you from making any further disclosure of this information unless further disclosure is expressively permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42-CFR Part II and State law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.