Paul H. Deutsch, MD, RPh, LLC
BOARD CERTIFIED INTERNAL MEDICINE
86 NEW LONDON TPKE
NORWICH, CT 06360
TELEPHONE: 860-889-6967, FAX: 860-885-1033

Authorization to Disclose Medical Record Information

PATIENT INFORMATION
Patient Name: ____ Date of Birth: ____________________
Patient Address: ____
City: ______________________ State: ________ Zip: _______________ Phone #: __________________________

RELEASE INFORMATION
- o I authorize Paul H Deutsch, MD, RPh, LLC to Send my Medical Records to:
- o I authorize Paul H Deutsch, MD, RPh, LLC to Request my Medical Records from:

Name/Facility: ____
Address: ____
City: ______________________ State: ________ Zip: _______________ Phone #: __________________________

Purpose of Request: (Please Initial)
____ Personal ____ Continuation of Care ____ Legal ____ Insurance ____ Transfer of Care
____ Other: (please specify)____

Information to be Released (Please Initial)
____ Complete Medical Record ____Office Visits ____ Lab Results ____Imaging Reports ____ Other:
Specific Information:____
Specific Dates: ____

Legally Protected Information (Please Initial)
The following items will not be included, unless specifically authorized.
____ Genetic Testing ____ HIV/AIDS Results ____Sexually Transmitted Diseases ____Psychiatric Health
____ Substance Use Disorders ____ Reproductive Health Care Services

Fees:
We may charge a fee for asking and sending copies (HIPAA 45CFR, 164.524).
At no time will the cost-based fees exceed Connecticut law (Section 20-7c of the CT General Statutes)

Preferred format for Release of Medical Records (Please Initial)
____ Paper ____ Fax

- I understand I can cancel this authorization at any time. I must give a written statement to Paul H Deutsch, MD, RPh, LLC to cancel. Canceling won't affect information already shared with consent. I understand this authorization is good for 12 months, unless noted or canceled. Please note an expiration date if less than 12 months: ______________________.
- I understand that granting the release of this health information is not required. I do not need to sign this form to get care.
- I understand that my health record may have details on my mental health, substance abuse disorders or otherwise sensitive information. Releasing information may lead to unauthorized re-release, which may not be protected by federal confidentiality rules.

Signatures
Patient or Legal Representative Signature: ____ Date: ______________

Printed Name: ____ Relationship to Patient: ______________________