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

Permission to Communicate

	By initialing this box , I am revoking all previous Permission to Communicate forms.

Patient Name: _____ Date of Birth: _____

I authorize Paul H Deutsch, MD RPh, LLC to share my protected health information with family members or others as designated by me below. This permission is NOT an authorization to release medical records, or a consent to treatment.
This permission also authorizes Paul H Deutsch, MD, RPh, LLC to communicate with authorized persons by phone (including voice messages), in person, or by other means acceptable by Paul H Deutsch, MD RPh, LLC.

1.) **Name:_____**

Phone Number: _____ Relationship to Patient:_____

2.) **Name: _____**

Phone Number: _____ Relationship to Patient:_____

3.) **Name:_____**

Phone Number: _____ Relationship to Patient:_____

I understand that I am under no obligation to provide Paul H Deutsch, MD RPh, LLC with this Permission to Communicate, and that Paul H Deutsch, MD RPh, LLC will not condition treatment, payment, or enrollment/eligibility for benefits on my decision to provide or not provide this form. I understand that I may revoke this Permission if I so choose. I can revoke this Permission either by completing a new Permission to Communicate form and indicating my revocation on the form, or by notifying Paul H Deutsch, MD RPh, LLC in writing of my revocation. Communications should be sent to : Paul H Deutsch, MD RPh, LLC at 86 New London Turnpike, Norwich, CT 06360, Attention: Privacy Officer.

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature of Patient: _____ Date: _____