Authorization for the Use or Disclosure of Protected Health Information

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

86 New London Turnpike Norwich, CT 06360
Phone: 860 889-6967 Fax: 860 885-1033

As required by the Health Insurance Portability and Accountability Act of 1996 Paul Deutsch M.D., R.Ph., LLC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the users and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, ________________________ (print name) DOB: ______________hereby authorize the use and disclosure of the following health information that pertains to me:

- ○ All Medical Records
- ○ Lab Results From: _______________ To: _______________
- ○ Diagnostic Imaging From: _______________ To: _______________
- ○ Progress Notes From: _______________ To: _______________

For the following purpose

- ○ Switching PCP Practice
- ○ Continuity of Care
- ○ Other _____________________________________

I authorize the following persons to make these disclosures of my health information:

____

I authorize the following persons to receive these disclosures of my health information:

____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It

may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.______ (initial here)

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Paul H. Deutsch M.D., R.Ph., LLC I further understand that any such revocation does not apply to the extent that persons authorize to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire one year from the date the authorization is signed.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that Paul H. Deutsch M.D., R.Ph., LLC will receive compensation for the uses and disclosures that I have authorized.

_________________________________ _________________________________
Signature Date

REVOCATION SECTION

I hereby revoke this authorization.

_________________________________ _________________________________
Signature Date