Office of Paul H. Deutsch M.D., R.Ph., LLC
HIPAA PRIVACY NOTIFICATION / DISCLOSURE TO FAMILY AND FRIENDS

_____

First Name Last Name Middle Initial

Primary Phone: _____ Date Of Birth: _____

We may need to contact you by phone about results, appointments, or referrals. You may request the list of people involved with your care be expanded or restricted. You have the right to amend this information at any time. To facilitate contacting you in a timely manner and to comply with federal HIPAA regulations, please complete the information below.

_____ You may only speak to me personally.

_____ You may call me at work. Work Phone: _____ Ext. _____

_____ You may call my cell phone. Cell Phone: _____ Text: YES / NO

_____ You may leave a message on my answering machine or voice mail regarding those items checked below at:

_____ Home _____ Work _____ Cell

_____ You may leave a message regarding those items checked below with the following family members:

___ Spouse/Name: _____Phone: _____

___ Children/Name: _____Phone: _____

___ Parent/Name: _____ Phone: _____

___ Other/Name: _____Phone: _____

___ Other/Name: _____Phone: _____

	BLOOD WORK		**REFERRALS**		**APPOINTMENTS**
	PAP SMEAR		**MAMMOGRAM**		**CULTURES**
	XRAYS		**EKG**		**CT/MRI**
	PRESCRIPTIONS		**ALL OF THE ABOVE and /or any other test performed**		

I understand that Paul H. Deutsch M.D., R.Ph., LLC will make reasonable efforts to accommodate this request for as long as I am a patient; but I can request a change at any time. I further understand that in some emergency situations, my protected health information may be released.

_____ _____

Patient/ Parent/ Guardian Signature *Date*

RX HISTORY CONSENT

By signing below, I agree to allow Paul H. Deutsch M.D., R.Ph., LLC to review any prescription history available to my electronic health record.

_____

Signature