



**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.**

Specific medical records. **Required** (*what medical records 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: Electronic Records**

"Because Paul H. Deutsch MD, R.Ph., LLC uses and/or maintains an electronic health record ("EHR") and/or other systems to maintain your protected health information electronically, we must provide you a copy of your protected health information that is maintained by the EHR or other systems in electronic format, if you so desire, and in the format you chose if that format is readily producible."

PDF File on a USB thumb drive

On a CD

Paper Copy

\_\_\_\_\_ I understand that you may charge me a reasonable cost based fee for the labor and technical skill to produce the electronic copy, as well as the cost of supplies for providing electronic media in the format you have requested or agreed to.

**Section D: 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.

\_\_\_\_\_ 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\*\*\***

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**FOR OFFICE USE ONLY:**

**Authorization added to patient's medical record on:** \_\_\_\_\_.

**Authorization verified by** \_\_\_\_\_ **on** \_\_\_\_\_.

**REDISCLASURE 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 expressly 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.*