AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Dr. Michelle Deutch to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

Patient authorizes communication with family/friends regarding your care and test results.

Name_____ Phone #_____ Relation _____

Name_____ Phone #_____ Relation _____

Patient authorizes communication with family/friends regarding your account and billing.

Name_____ Phone#_____ Relation _____

Name _____ Phone # _____ Relation _____

Patient authorizes communication with a primary care physician or other physician (first and last name):

1._____ Phone # _____

2. _____ Phone # _____

Best way to contact you regarding messages, responses, appointment reminders etc. (mark all that apply).

Home phone__ Work Phone __ Cell Phone __ Email __

May we leave a message with whomever answers the phone or on voicemail?

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

May we fax and/or email to other providers if necessary for medical care? Yes No NA

Signature of patient (or patient's representative) _____

Printed legal name of patient (or patient's representative) _____

Date _____