Direct Doctors
An Innovative Family Medicine Practice

Authorization for Use and Disclosure of Private Health Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize to _____ to release healthcare information of the patient named above to:

Dr. Mark Turshen, MD
Direct Doctors, Inc.
320 Phillips Street, Suite 203
Wickford, RI 02852
Phone: (401) 400-2699

**** Please FAX to (401) 406-2699 ****

Description of Private Health Information to be Released
I authorize the above provider to release protected health information to Direct Doctors, Inc. for the purpose of medical treatment. This may include information pertaining to mental health, alcohol or drug use, and HIV status. This authorization will expire in one year and may be rescinded at any time.

Specific information to be disclosed:

- Problem list or pt summary page
- Record of immunizations
- Office notes from the past 2 years
- Diagnostic studies (lab, radiology, etc) from the past two years
- Medication list
- Health Maintenance page or records of health maintenance testing
- Any available disease management flow sheets

Other: _____

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person/company specified above except to the extent that the person/company has already taken action on the disclosure provisions contained in this document.

_____ Date: _____
(Signature of Patient)