



## Authorization for Use and Disclosure of Private Health Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

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

Dr. James Hedde, DO  
Dr. Lauren Hedde, DO  
Dr. Mark Turshen, MD  
Direct Doctors, Inc.

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

**Please send all records by Fax to 401-406-2699. Please do not send CDs.**

### 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 This authorization may be rescinded at any time.

Specific information to be disclosed:

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

Specifically looking for: \_\_\_\_\_

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.

\_\_\_\_\_  
(Signature of Patient)

Date: \_\_\_\_\_