



DOCTORS DIRECT LLC - DR. DEREK MURPHY DO
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PATIENT CONSENT TO SHARE PROTECTED INFORMATION REGARDING HEALTH

****this form will allow us to leave a message on voicemail or with individuals involved with your health care.**

NAME of Patient: _____ **Phone Number/ Other:** _____

DATE OF BIRTH: _____ **SSN:** _____

DOCTORS DIRECT LLC 13578 E 131st Street, Fishers, IN 46037

I the undersigned hereby consent to DOCTORS DIRECT leaving a voicemail message at the numbers above and/or discussing with the individuals listed below information related to my protected health information (PHI). These communications may include, but are not limited to, appointment reminders, medications, pre-registration, prior authorization, insurance items, billing and any other information pertaining to the clinical health services, such as laboratory and test results. I understand that this consent is only valid at the office above.

With my consent, DOCTORS DIRECT may discuss my PHI with the following individuals:

NAME: _____ **DOB:** _____

Relationship: _____ **PHONE:** _____

NAME: _____ **DOB:** _____

Relationship: _____ **PHONE:** _____

NAME: _____ **DOB:** _____

Relationship: _____ **PHONE:** _____

I understand the information listed above may be communicated via: fax, photocopy, verbal communication, telephone, voicemail and/or direct mail.

If certain information is NOT to included, please list here: _____

Your rights with respect to this consent:

I understand that I have the right to revoke this consent at any time by sending a written statement to Doctors Direct LLC as above addressed, except to the extent Doctors Direct has already made a disclosure in reliance upon my prior consent. Unless revoked, this consent is valid until the expiration listed below. A photocopy of a signed consent is acceptable, provided that it is apparent that the consent was signed and dated prior to photocopying. I further understand that this consent does not permit the release of my actual medical records to the individuals listed above. Such release will only be made if I sign a separate valid authorization

If I fail to specify an expiration date, even no condition, this consent will be valid for one year: _____

Signature: _____ **Date:** _____

IF signed by legal rep then relationship: _____ **Signature of Witness:** _____

