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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name (LAST/FIRST): _____

SSN: _____ DOB: _____

Address: _____

City: _____ STATE: _____ ZIP: _____

I AUTHORIZE THE FOLLOWING INDIVIDUAL OR OFFICE TO MAKE DISCLOSURE

I authorize the use of disclosure of the above named individual's health information as described below:

This information may be disclosed to and used by DOCTORS DIRECT

Doctors Direct LLC

Dr. Derek Murphy

13578 East 131st Street STE 101

Fishers, IN 46037

TEL: 317-863-0830

I represent the above-named patient, and as shown by the following authorization, they have authorized you to produce their medical records to me. Pursuant to the HITECH Act, 42 U.S.C.A. §17935(e)(1), and its implementing regulations, 45 CFR 164.524(c)(4)(i), we are requesting, **in an electronic format ONLY**, a complete copy of the patient's medical records from _____ to **PRESENT DATE as dated below**. Please be aware that the HITECH Act applies to requests by third-parties, like our medical office, just the same as it applies to requests by patients: "if requested by an individual, a covered entity must transmit the copy of protected health information directly to another person designated by the individual." Federal Register January 25, 2013 Vol 78 No. 17, Page 5634.

The records should include, if applicable, their Hospital admission face sheet; Discharge summary; Admission history and physical; Progress notes; Orders; Consultation; Radiology reports; Lab values; Graphic vital signs; Anesthesia record; Operative reports and notes; Pathology reports; Recovery room; Nurses notes; Medication records; Outpatient records; Emergency room records; Special diagnostic tests; and Fetal strips.

We are not requesting paper copies. Do not bill us for paper copies if you send these instead which we will accept but are not requesting. The HITECH Act and its regulations do not allow you to bill for paper copies when an electronic copy has been requested.

Patient SIGNATURE: _____

Date: _____

Your Rights With Respect to This Authorization:

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, as provided in CFR 164.524. I understand that if I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of the form upon request. I understand that this release also pertains to my medical records concerning treatment, including but not limited to, information regarding treatment for the alcohol/substance abuse, communicable diseases, including AIDS or HIV, and/or psychiatric or mental health problems. I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing and present my written withdrawal to the health info management department of the entity listed above. I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will expire on the following date/ event or condition specified below. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re: disclosure and the information may not be protected by federal confidentiality rules. If I have questions I can contact Dr. Murphy. Expiration of this is as stated or 180 days whichever comes sooner.

