HIPAA COMPLIANT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

[This form must be used for each disclosure or use of protected health information other than for care and treatment, billing and payment, and evaluations of quality of care. Please include a copy of your driver's license or state issued ID. Fax or email this completed document to 903.839.2494 or to jgarraway@aalabs.com.]

I,_____, authorize the use/disclosure of the patient's health information, as identified and described below:

1) PATIENT IDENTIFICATION:
   Printed Name: _____
   Address: _____
   Phone #: _____
   Email: _____
   Date of Birth: _____ Last 4 digits of SSN: _____
2) PHYSICIAN(s) OR LABORATORY AUTHORIZED TO DISCLOSE THE PATIENT'S HEALTH INFORMATION:
   _____
   _____
   _____
3) HEALTH INFORMATION TO BE DISCLOSED: (including records/documents received from any other physicians, health care providers, therapists, or counselors):
   - ☐ Reports on laboratory tests
   - ☐ Other: _____
4) DATE RANGE OF HEALTH INFORMATION AND DOCUMENTS AUTHORIZED TO BE RELEASED:
   FROM: _____ TO: _____
5) PURPOSE OF DISCLOSURE/USE:
   _____
   _____
   _____
6) TO WHOM AND WHERE TO SEND DISCLOSED HEALTH INFORMATION: I authorize the disclosure and use of the protected health information described above to the following person(s) or organization(s) and/or their agents, representatives or employees (provide name, address and telephone number):
   _____
   _____
   _____

7) RE---DISCLOSURE: I understand the information disclosed by this Authorization may be subject to re---disclosure by the recipient(s) and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facilities, their employees, and officers are herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

8) TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION: Except to the extent that action has already been taken in reliance on this Authorization, I understand this Authorization is voluntary and that I may revoke it at any time by submitting a notice in writing to the Record Custodian or the Privacy Officer at Advanta Toxicology, except the extent that action has been taken in reliance on the Authorization before the facility's receipt of such revocation. This Authorization will expire in one (1) year from the date it was signed or when the patient identified above is discharged from care of the physician or health care provider identified above, or in the event that the patient is not admitted to care of the physician or health care provider identified above, whichever occurs first.

9) RIGHTS/SIGNATURE OF PATIENT/PERSONAL REPRESENTATIVE REQUESTING DISLOCUSRE: I understand that my refusal to authorize disclosure of my/the patient's personal healthy information will have no effect on my/the patient's enrollment, eligibility for benefits, ore the amount Medicare pays for the health services I/the patient receive. I can inspect or copy the protected health information to be used or disclosed. I may see and receive a copy of the Authorization. I authorize the herein named person, and/or organization to disclose the protected health information specified above. A facsimile, photo static, carbon or other copies of this Authorization are intended and shall be treated as an original.

By signing below, I acknowledge that I have read and understand this Authorization form.
Signed this_____day of_____, 20_____.

_____

Signature of Patient

_____

Signature on behalf of Patient, if Patient is unable to sign

_____

Relationship to Patient

If other than Patient making this request, individual must provide documentation/proof to proceed with the release of records.