

Accu-Chem Laboratories

Authorization for Disclosure of Patient Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *By signing this authorization I authorized the use or disclosure of the above named individual's health information as described below.*

2. *The following individual or organized to make the disclosure:*

Accu-Chem Laboratories

990 N. Bowser Rd., Suite 800

Richardson, TX 75081

Phone: 1-800-451-0116 FAX: 972-231-6016

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

Laboratory Results Other (please specify) _____

Ordering Physician: _____ Dates: _____

Clinical tests ordered: _____

4. *The information may be disclosed to and used by the following individual or organization.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of: _____

5. *In accordance with your rights under, and subjective to certain restrictions imposed by, HIPPA, you may inspect or copy your PHI in the designated record set maintained by Accu-Chem Laboratories for as long as the PHI is maintained in the designated record set.*

6. *You have the right to revoke this authorization, in writing, at any time, except to the extent that Accu-Chem Laboratories has taken action in reliance on it. A revocation is effective upon receipt by Accu-Chem Laboratories of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above*

7. *This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of civil Rights that this authorization is not in compliance with requirements of HIPPA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Accu-Chem Laboratories, or (d) six years from the date this authorization was executed.*

8. *I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that i may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information many not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: **privacyofficer@accuchem.com***

Signature of patient or legal representative Subscribed and sworn before me on the _____
day of _____,

Date: _____

Notary Public in and for the State of: _____
Commission Expires: _____