Quest Diagnostics

PATIENT AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize Quest Diagnostics to use and/or disclose my protected health information (which may pertain to my diagnosis and treatment, laboratory test results, medical history billing information, ordering and/or treating physicians, and/or other related information, including but not limited to results such as HIV, sexually transmitted disease, and drug testing information) as specifically identified below and in the original request attached to this authorization and to the person(s) named in that request. I understand that this authorization will expire on _____ or one year from the date subscribed below, whichever is sooner.

I authorize attorney(s) and their legal staff, as well as the appropriate Quest Diagnostics and its employees, to use and/or disclose my PHI in accordance with this authorization.

This use and/or disclosure of my PHI is at my own request. I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the person or party receiving it; in that case, the information may no longer be protected under federal law.

Notice to the patient:

If we are requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services to you on the receipt of this signed authorization except if you are participating in a research project;
- You may request a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization;
- We must provide you with a copy of the signed authorization; and
- This authorization only covers PHI that is disclosed by Quest Diagnostics. The information could be redisclosed by the person(s) who receive it and, in that case, your PHI will not be protected by the HIPAA privacy and security rules.
- You have the right to revoke this authorization at any time, provided that you do so in writing, except to the extent that we have already relied on this authorization to use or disclose your information.

PHI Requested (*REQUIRED*):

Date(s) of Service: _____ Test(s) Performed: _____

Patient's Information (*#1 is Required*):

1. Patient's Name _____ _____ _____
   First Name Middle Name Last Name

2. Date of Birth: _____
3. Social Security Number (or last four digits) _____ OR
3. Ordering Physician's Name (or practice name) _____
4. Accession Number _____

In addition to the above two items, any <u>ADDITIONAL TWO</u> items must be provided:

5. Gender ○Male ○Female
6. Patient's Address (Street, City, State, Zip): _____
7. Insurance ID Number: _____
8. QD patient invoice statement number._____
9. Ordering physician's address _____
10. Ordering physician's phone number _____

Signature:

I have reviewed and I understand this Authorization.

Name (print) _____

Signed: _____ Date:_____
(Patient)

Or By:_____Date: _____
(Patient's Representative)

Description of Representative's Authority: _____

Please send the requested information to the following:

Name: _____ Address: _____

FAX: _____ Account #:_____

Patient Revocation (to be signed only if you wish to revoke the Authorization, except to the extent that we have already relied on this Authorization to use or disclose your information).

I hereby revoke this authorization to use and/or disclose my protected health information. This revocation is effective on the date that it is signed below, and Quest Diagnostics may not use or disclose my Protected health information that is subject to this authorization after this date. I understand that if Quest Diagnostics has previously relied upon this authorization to use and/or disclose my PHI, that such previous use and/or disclosure may not be revoked.

Signed: _____ Date: _____

Quest Diagnostics Incorporated
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