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

I authorize Quest Diagnostics to use and/or disclose my protected health information (for example, my laboratory test results, billing information and/or other related medical information, including but not limited to results such as HIV, sexually transmitted disease, and drug testing information) as specifically identified below, to the person(s) named in this request. I understand that this authorization will expire when Quest Diagnostics has provided the requested information.

I authorize attorney(s) and their legal staff, as well as appropriate Quest Diagnostics 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 privacy 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, upon request;
- This authorization only covers PHI that is used or 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: and
- 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.

Patient's Information: (*REQUIRED)*

1. Name: _____
First Name Middle Name/Initial Last Name

Provide all other names (nicknames, alternate spellings, former name, etc.): _____

Provide TWO of the following LEVEL ONE Identifiers and ONE LEVEL TWO; OR ONE LEVEL ONE Identifier and TWO LEVEL TWO Identifiers

LEVEL ONE Identifiers

2. Date of Birth: _____
3. Phone number: _____
4. Social Security Number (last four digits): _____

LEVEL TWO Identifiers

5. Patient's Address (Street, City, State, Zip): _____
6. Insurance ID Number: _____
7. Patient invoice number: _____
8 Ordering provider's name (or practice name):_____
9. Ordering provider's address: _____
10. Ordering provider's phone number: _____

PHI Type (*REQUIRED*): ☐ Laboratory Test results ☐Billing information ☐ Laboratory Order forms

Date(s) of Service: _____

Signature:
I have reviewed this document and my authorization is below.

Name (print): _____

Signed: _____ Date: _____
(Patient)

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

Description of Representative's Authority _____
(Required: Documentation of the Representative's Authority must be attached. NOTE: Parents of minors do not need to provide documentation.)

Please send the requested information to the following:

Name: Records Deposition Service Title:_____

Address: P.O. Box 5054, Southfield, MI 48086-5054 Phone Number: (248) 357-3330

Or FAX: (248) 357-3337

Or Email: requests@recdep.com (Please Print)

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: _____

For Internal Use Only:

Quest Diagnostics Nichols Institute
San Juan Capistrano, PDM and Cleveland Heart Lab
33608 Ortega Hwy.
San Juan Capistrano, CA 92675