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: ____________________________