AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Pathology Laboratory Associates

Patient Name	Phone No.	Date of Birth	Social Security No. last 4

I hereby authorize Pathology Laboratory Associates, _____
and its duly authorized agents and employees to ☐ **Release to or** ☐ **Obtain from** the person or organization listed below my individually identifiable health information for the use and disclosure described below. I do not authorize further release to any third party.

PERSON OR ORGANIZATION INFORMATION IS TO BE RELEASED TO OR OBTAINED FROM/PURPOSE OF RELEASE

Person/Organization to release to or obtain my information from (include address)			*Purpose of release:*
Name of Person or Organization			☐ Filing insurance ☐ Continued treatment
Street			☐ Request of patient or their legal representative ☐ Other (specify):
City	State	Zip	_____

INFORMATION TO BE USED OR DISCLOSED – *Check all that apply*

Laboratory Reports
Surgical Lab Specimen
Path Case #:
Paraffin Block
Microscopic Slides
View Electronic Record
Other (specify): _____

TREATMENT DATES REQUESTED – *Check one*

☐ All dates of service ***OR*** ☐ Treatment dates between _____ and _____

REQUEST TO RECEIVE INFORMATION ELECTRONICALLY

I would like my information released to me in the following electronic format:
CD (disk); ***or*** Secure electronic mail (e-mail); ***or*** Unsecure e-mail

If e-mail, send to the following e-mail address: _____
I understand that by requesting secure e-mail, my information will be transmitted in an encrypted format and that I will receive notice to establish a user name and password to limit access to my information. If requesting unsecure e-mail, I understand that my information could be viewed by others without the security protections afforded by encryption, user name and password. Regardless of the method chosen, transmission of the information may require multiple messages depending on the volume of material involved.

Faxed Results, LAB USE ONLY: Results will be faxed to patients by specific request according to the Laboratory Outreach Fax/Called Results Policy and Lab Result Availability Procedure. Fax to:

I UNDERSTAND:

- This may include records involving *communicable or venereal disease, psychiatric, drug abuse and/or alcoholism.* **The information authorized for use or disclosure may include information which may indicate the presence of communicable or non-communicable disease.**
- I may cancel this authorization at any time by sending written cancellation to the Pathology Laboratory Associates, Inc. privacy officer. This cancellation will not apply to information already released based on this authorization.
- This authorization automatically ends twelve (12) months after the date signed.
- The person or organization receiving information based on this authorization could re-release the information to others and federal law would no longer protect it. I release the hospital and its staff, employees, officers and directors from any responsibility from such re-release.
- ***With this knowledge, I voluntarily give my consent to the use and disclosure of individually identifiable health information including information concerning my identity and release Pathology Laboratory Associates, Inc. and its duly authorized agents and employees from any liability in connection with the use or disclosure of the information contained herein.***

Add any extra names to be released to:

Signature of Patient/Personal Representative	Date	Time	Patient/Personal Representative ID verified by:
Authority of Personal Representative to act on behalf of Patient			☐ Picture ID ☐ Other (specify): _____
Reason Patient Unable to Sign			
Signature of Witness	Date	Time	

TRANSLATION: *This certifies that this Authorization was read to the patient or their personal representative in his/her native language; all representations that appear in the Authorization were understood and authorized by the patient or their personal representative.*

Interpreter's Signature	Date	Time

DRUG/ALCOHOL ABUSE RECORDS: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). These Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise specified by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Communicable or Venereal Diseases: Oklahoma State Law (63 Okla. State. 1-502.2-3) mandates that medical information cannot be released unless the consent form includes the warning outlined above in boldface type. When such information is released, it cannot contain information from which the patient can be identified unless release of that identifying information is authorized by the patient, by a court order, by the Department of Health or by operation of law

CONFIDENTIAL INFORMATION