PLA Fax/Email Verification Form

The undersigned Client hereby authorizes Pathology Laboratory Associates Inc. (PLA) and its affiliated entities to send Protected Healthcare Information as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. Parts 16064, to the following email address(es) to the extent such transmission is deemed by PLA to be reasonably necessary as part of the professional business relationship between PLA and Client:

Email Address(es): ____

Fax Number(s) ____

____

(Please include all fax numbers/email addresses to which confidential patient laboratory results may be transmitted)

Client acknowledges to PLA that Client is solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location, access and use of such email complies with all applicable HIPAA regulations. Client may revoke this authorization or change the email address only by giving PLA at least five (5) days prior written notice which notice must be faxed to RML Client Services at facsimile number **(918) 416-0506**.

Client Name:____**PLA Client #:**__________

Client Address: ____

Physician/Provider name(s): ______________________ ______________________

____

Signature:____

Printed Name:____

Title/Position:____

Phone Number:____

PLEASE SIGN AND FAX A COPY OF THIS FORM TO:
PLA Client Services Department
Facsimile: (918) 416-0506
ATTN: Gaylene Hayes

OR EMAIL A COPY TO: Gaylene.hayes@plapath.com