ASSOCIATES IN PATHOLOGY SERVICE CORPORATION

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____ Previous Last Name(s)_____
Address_____ Date of Birth_____
City, State, Zip_____ Telephone #_____

I authorize the use and/or disclosure of my protected health information:
I understand that my protected health information that I am authorizing to be disclosed may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and/or infection with the Human Immunodeficiency Virus (HIV). **If I do not intend for this information to be disclosed, I understand that I will need to cross out the statement above and initial here.**_____

INFORMATION TO BE DISCLOSED TO

Organization/Name_____
Address_____
City_____ State_____ Zip_____
Telephone #_____

INFORMATION TO BE DISCLOSED INCLUDES

Dates of Service_____

☐ Cytology Slides/Reports_____
☐ Pathology Slides/Reports_____
☐ Other (Please Specify)_____

PURPOSE FOR DISCLOSURE

☐ Medical Care ☐ Insurance ☐ Legal
☐ Personal ☐ Disability Determination ☐ Worker's Compensation
☐ Other (Please Specify)_____

FURTHER DISCLOSURE

I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

YOUR RIGHTS

- I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.
- I understand I have the right to inspect and receive a copy of the materials to be disclosed.
- I understand that I am entitled to a copy of this authorization after I sign it. A copy of this authorization is as valid as the original.
- I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.
- I understand that this authorization is effective for 12 months from the date signed, or on the occurrence of the following event (specify):_____

By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form.

_____ _____ _____
Patient's or Legal Representative's Signature Relationship to Patient Date