BioReference LABORATORIES

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY

Patient's Name: _____
(Last) (First) (Middle)
Date of Birth: ____/____/____Preferred Tel. No.:___/_____/_____circle one: cell home business
Month/Day/Year
Address: _____
(Street) (City) (State) (Zip Code)

I authorize BioReference Laboratories, Inc to disclose my (Please request/check all that apply):

□ Lab Test:
Test name _____ _____LAB ID # _____Ordering MD_____Date Collected_____

□ Path Report(s):
Test name _____ _____LAB ID # _____Ordering MD_____Date Collected_____

□ Other:
Test name _____ _____LAB ID # _____Ordering MD_____Date Collected_____

Records to be disclosed ____ do include ____ do not include HIV-related information.

____ do include ____ do not include Alcohol and Drug Abuse information

____ do include ____ do not include Psychiatric information

To □ Healthcare Provider □ Insurance Company or Designee □ Attorney

□ Court □ Law Enforcement □ Employer □ Other: _____

Name: _____

Address:
_____Fax:_____

Reason for Disclosure □ Patient Request □ Other: _____

We will not condition treatment or payment on whether you sign this authorization. However, if you refuse to sign we will not release your records.

I understand that this authorization is valid for one year from this date or until _____and may be revoked by me in writing at any time except to the extent BioReference Laboratories, Inc. has already taken action based on my authorization (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest a claim under the policy).

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of alcohol and drug abuse information and/or psychiatric information and/or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).
If I am authorizing the release of HIV/AIDS, Alcohol or Drug treatment, or mental health treatment related information the recipient(s) is prohibited from redisclosing the information without my authorization unless permitted to do so under federal and state law.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient Signature: _____ Date: _____
Personal Representative
Signature: _____ Print Name: _____

Authority: _____ Tel. No: _____

Address: _____ Date: _____

{Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf}

To request records or to revoke authorization send a written request attention to:
HIPAA Privacy Office
481 Edward H. Ross Drive
Elmwood Park, NJ 07407,
Fax #: 201-791-1941

_____

For BRLI Use Only
Date Received: (MO/DY/YR) _____/_____/_____
Disposition of Request: _____ GRANTED _____ DENIED _____ PARTIALLY DENIED
Patient Notified in Writing of Response on This Date: (MO/DY/YR) _____/_____/_____
Fee Charged for Fulfilling This Request (if applicable): $ _____
Full Name of Staff Member Processing This Request:

- ☐ Government Issued Identification shown
- ☐ Copy issued to patient
- ☐ Copy sent to HIPAA Privacy Office