Quest Diagnostics

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PATIENT AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize Quest Diagnostics to use and/or disclose protected health information (for example, my laboratory test results, billing information, and/or other related medical information, including but not limited to HIV, sexually transmitted infections, communicable diseases or infections, genetic testing and alcohol and drug abuse treatment records OR drug testing covered by 42 CFR Part 2) as specifically identified in the original subpoena attached to this authorization and to the person(s) named in the subpoena. (Photocopies, facsimile transmissions, and similar non-original versions of the subpoena are unacceptable.) This authorization will expire when Quest Diagnostics has provided the required information.

I understand that the following employees of Quest Diagnostics are authorized to use and/or disclose my PHI (in accordance with this authorization): employees in Client Services, Billing Services, Legal and Compliance, Operations, Medical, and Human Resources. I authorize attorney(s) and their legal staff, and/or Court clerks as required by the subpoena attached to this authorization to receive my PHI.

I understand that my PHI will be used and/or disclosed for the purpose(s) indicated on the attached subpoena. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal privacy law.

Notice to the patient:
If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services to you on the receipt of this signed Authorization except if you are participating in a research project;
- You may request a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization;
- We must provide you with a copy of the signed authorization upon request;
- This authorization only covers PHI that is used or disclosed by Quest Diagnostics. The information could be redisclosed by the person(s) who receive it and, in that case, your PHI will not be protected by the HIPAA privacy and security rules; and
- You have the right to revoke this Authorization at any time, provided that you do so in writing, except to the extent that we have already relied on this Authorization to use or disclose your information.

PHI Requested (*REQUIRED*): ☐ **Laboratory Test results** ☐ **Billing Information** ☐ **Laboratory Order forms**

Specific Date(s) of service: _____

Patient's Information

1. **Name:** _____
First Name Middle Name/Initial *(Please Provide)* Last Name

Provide all other names (nicknames, alternate spellings, former names, etc.): _____

Provide TWO of the following LEVEL ONE Identifiers and ONE LEVEL TWO; OR ONE LEVEL ONE Identifier and TWO LEVEL TWO Identifiers:

LEVEL ONE

2. Date of Birth: _____ *(MM-DD-YYYY)* 3. Phone number: _____

4. Social Security Number (last four digits): _____

LEVEL TWO

5. Patient's Address (Street, City, State, Zip): _____ *(provide multiple for time frame requesting records)*

6. Insurance ID Number: _____ 7. Patient Invoice Number: _____

8. Ordering provider's name (or practice name): _____

9. Ordering provider's address: _____ 10. Ordering provider's phone number: _____

Signature: I have reviewed this document and my authorization is below.

Name (print): _____ Signed: _____ Date: _____
(Patient)

Or By: _____ Date: _____
(Patient's Representative)

Description of Representative's Authority _____
(Required: Documentation of the Representative's Authority must be attached. Note: Parents of minors do not need to provide documentation.)

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Patient Revocation (to be signed only if you wish to revoke the Authorization, except to the extent that we have already relied on this Authorization to use or disclose your information).

I hereby revoke this authorization to use and/or disclose my protected health information. This revocation is effective on the date that it is signed below, and Quest Diagnostics may not use or disclose my protected health information that is subject to this authorization after this date. I understand that if Quest Diagnostics has previously relied upon this authorization to use and/or disclose my PHI, that such previous use and/or disclosure may not be revoked.

Signed: _____ Date: _____

For Internal Use Only:

Quest Diagnostics
1355 Mittel Boulevard
Wood Dale, IL 60191
P: 630-595-3888, Fax: 630-364-4172

PLEASE SEND REQUESTED INFO TO:

RECORDS DEPOSITION SERVICE, INC.
P.O. BOX 5054
SOUTHFIELD, MI 48086-5054
P:248-357-3330 F:248-357-3337 E: REQUESTS@RECDEP.COM