PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FORM

Please complete all items marked with ⊗

Please Print: ⊗ **Patient Last Name** _____ ⊗ **Patient First Name** _____

⊗ **DOB:** _____/_____/_____ (MM/DD/YYYY) ⊗ **SSN: XXX-XX-**_____ ⊗ **Daytime Phone Number** (___)_____-_____

AUTHORIZATION

I authorize the disclosure of my protected health information as described herein.

1. Pursuant to the HIPAA Privacy Rule, **I authorize TriCore Reference Laboratories to disclose** the protected health information described in 1.a., 1.b. and 1.c**.**

⊗ **1.a.** The records authorized to be released include **Dates of Service** _____/_____/_____ **through** _____/_____/_____

⊗ **1.b.** The records authorized to be released include **ONLY** _____

OR (check only one)

☐ Laboratory MEDICAL RECORDS ☐ Laboratory BILLING RECORDS ☐ Laboratory MEDICAL AND BILLING records

⊗ **1.c.** New Mexico Specially Protected Information – I acknowledge that such records may include and/or contain information regarding any or all of the following conditions or diseases and the treatment thereof. I specifically authorize disclosure by **INITIALING ALL THAT APPLY** (types not initialed will **NOT** be disclosed):

Any and all information and laboratory records that relate, in any way, to any

_____ drug/alcohol/substance abuse testing, history or treatment
_____ emotional/behavioral heath/psychiatric testing, condition or treatment
_____ Human Immune Deficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS) testing or treatment
_____ Sexually Transmitted Diseases testing or treatment
_____ genetic testing

⊗ **2.** **I authorize the following person(s) to receive** the protected health information described in paragraphs 1.a., 1.b., 1.c.:

Please Print: **Last Name** Richmond c/o Records Deposition Service **First Name** Victoria

Please Print: **Address** 29100 Northwestern Hwy., Ste. 300, Southfield, MI 48034 P (248) 357-3330, F (248) 357-3337 E requests@recdep.com

3. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

4. I understand that I may ***revoke*** this Authorization at any time by sending a letter to TriCore Reference Laboratories, except to the extent that TriCore Reference Laboratories may have already taken action in reliance on this Authorization. If I do not sign, or if I later revoke, this Authorization, the services provided to me by TriCore Reference Laboratories will not be affected in any way.

5. This authorization does not permit the person or organization listed in Paragraph 2 (two) to obtain or request from TriCore Reference Laboratories oral statements, opinions, interviews, or reports that are not already in existence.

6. If applicable, copying costs will be borne by the person or organization named in paragraph 2 (two).

7. This Authorization will ***expire*** one year from the date it is signed if no expiration date is listed below.

8. A photocopy or facsimile of this Authorization is as valid as an original.

9. I understand that a potential exists for information that is disclosed pursuant to this Authorization to be subject to ***re-disclosure*** by the recipient and therefore be no longer protected by federal confidentiality rules.

⊗_____ _____ _____

Signature, Patient or Legal Representative **(Relationship to patient)** **(Date)**

⊗ **Expiration Date (not to exceed 5 years)** _____/_____/_____

Based on: U. S. Dist. Ct. Rules D.N.Mex., Civil App. A, Form 1, NM R USDCT CIV App. A, Form 1; Effective September 9, 2008. Other resources:
45 CFR §§ 160, 164.524, 164.530 (i), 5 USC 552 A, NMSA 24-1-20, NMSA 24-2B-6, NMSA 24-21-7, NMSA 24-2E-2, NMSA43-1-19, NMRA 11-504