BioReference® | GenPath®

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

BioReference Health, LLC and its affiliates, subsidiaries and divisions, including but not limited to, Florida Clinical Laboratory, Inc., and GenPath® (collectively "BioReference®") understands that health information is personal, and is committed to protecting the privacy of your information. Because of this commitment, we must obtain written authorization before we may use or disclose protected health information ("PHI") for the purposes described below. This form provides that authorization and helps us make sure you are properly informed on how this information will be used and disclosed. Please carefully read the information below and complete all fields before signing this form.

PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____

Address:_____ Apt:_____

City:_____ State:_____ Zip:_____

Phone No.:_____ ☐ Cell ☐ Home ☐ Other

WHAT INFORMATION WILL BE DISCLOSED? I authorize BioReference® to disclose the following information:

☐ **Entire Record** ☐ **Laboratory Reports** ☐ **Laboratory Requisition Forms** ☐ **Billing Statements**

☐ **Other**:_____

Include the above information for the following date(s) of service: ___/___/___ to ___/___/___

WHAT IS THE PURPOSE OR USE OF THE DISCLOSURE? (Check all that apply)

☐ Patient's Request ☐ Medical Care ☐ Insurance ☐ Legal

☐ Other:_____

RELEASE INFORMATION TO:

☐ Self ☐ Attorney ☐ Insurance Company ☐ Healthcare Provider ☐ Employer

☐ Other:_____

Preferred Method of Delivery: ☐ Fax ☐ U.S. Mail ☐ Standard Email* ☐ Secure Email

**Standard email is not a secure means of communication and your protected health information that may be contained in our emails to you will not be encrypted. This means that there is a risk that your protected health information in the email could be intercepted and read by, or disclosed to, unauthorized third parties. You are willing to accept the risks associated with a non-secure unencrypted email communication from us containing your PHI.*

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

*Name:*_____ *Phone Number:*_____

*Address:*_____ *City:*_____ *Zip:*_____

*Fax Number:*_____ *Email:*_____

By placing my initials below, I specifically authorize the release of such information to the person(s) indicated on this form. (Please note that we will not release your information if not initialized)

Alcohol/Substance Abuse:_____ HIV/AIDS[1] :_____ Mental Health:_____

Genetic Testing:_____ Sexually Transmitted Disease:_____

[1] Any information indicating you have had an HIV test, or HIV infection, HIV-related illness or AIDS, or any informtion that cound indicate you potentially have been exposed to HIV.

ACKNOWLEDGEMENTS

Authorization for Release of Confidential HIV/AIDS Related Information

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is/are prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have the right to request a list of people who may receive or use my HIV/AIDS-related information without my authorization. If I am a resident of New York and experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212-480-2493 or the New York Commission of Human Rights at 212-306-7450. These agencies are responsible for protecting my rights.

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

I understand that I have a right to refuse to sign this authorization and my health care, the payment for my healthcare, and my health care benefits will not be affected if I do not sign this form, but BioReference will not be permitted to use or disclose my information as described on this authorization without my signature.

If I sign this authorization, I have the right to revoke it at any time. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. You may revoke this authorization by submitting a written request to the attention of the Privacy Officer, BioReference Health, LLC, 481 Edward H. Ross Drive, Elmwood Park, NJ 07407 or Privacy@BioReference.com.

I have the right to obtain a signed copy of this authorization. You may obtain a signed copy of this authorization by sending a writen request to the attention of the Privacy Officer, BioReference Health, LLC, 481 Edward H. Ross Drive, Elmwood Park, NJ 07407 or Privacy@BioReference.com.

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

This authorization expires on:_____, 20_____, or event that will trigger the expiration of this authorization is:_____

SIGNATURE

By signing below, I acknowledge that I have read and accept all of the above.

_____
Patient Signature or Personal Representative

Note: A personal Representative is an individual authorized, by law, to act on behalf of the patient. Examples include parents or legal guardians of unemancipated minors, health care agents, and powers of attorney.

_____
Name of the Personal Representative

_____ _____
Description of the Personal Representative's Authority Date

(For Residents of New York Only):
If you are requesting records on behalf of an adolescent patient (ages 12 – 18), the adolescent patient must sign below. (NYS Public Health Law §§ 17 and 18).

_____
Signature of Adolescent Patient

Please return this completed form to:

By Mail: BioReference Health, LLC
Attn: Customer Service Department
481 Edward H. Ross Drive
Elmwood Park, NJ 07407

By Email:
PatientPortal@BioReference.com

For questions regarding this form or BioReference's Patient Portal, please contact us at 1-888-279-0967