Quest Diagnostics Incorporated

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

I authorize Quest Diagnostics to use and/or disclose my protected health information (which may pertain to my diagnosis and treatment, laboratory test results, medical history, billing information, ordering and treating physicians, and/or other related information, including but not limited to HIV and drug testing information) as specifically identified below and in the original request attached to this authorization and to the person(s) named in that request. I understand that this authorization will expire when Quest Diagnostics has provided the requested information.

I authorize attorney(s) and their legal staff, as well as the appropriate quest Diagnostics employees, to use and/or disclose my PHI in accordance with this authorization.

This use and/or disclosure of my PHI is at my own request. I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the person or party receiving it; in that case, the information may no longer be protected under federal 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; and
- This authorization only covers PHI that is disclosed by Quest Diagnostics. The information could be re-disclosed by the person(s) who receive it and, in that case, your PHI will not be protected by the HIPAA privacy and security rules.
- 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:

Date(s) of Service: _____ Test(s) Performed: _____

Patient's Information (#1-3 are *required*):
1. Patient's Name (include all names used during the period of the request)

_____ _____ _____ 2. Date of Birth_____
First Name Middle Name Last Name (MM/DD/YYYY)

3. Social Security Number _____ OR 3. Ordering Physician's Name (or practice name) _____

In addition to the above three items, any ADDITIONAL TWO items must be provided:
4. Gender ☐ Male ☐ Female

5. Patient's Address:
Street_____
City_____ State _____ ZIP _____

6. Social Security Number (Unless provided above) _____

7. Insurance ID#_____

8. QD patient invoice statement number _____

9. Ordering physician's name (or practice name)_____

9. Ordering physician's address _____

11. Ordering physician's phone number_____

Signature:
I have reviewed and I understand this Authorization.

Name (print)_____

Signed: _____ Date: _____
(Patient)

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

Description of Representative's Authority _____

This authorization will expire when Quest Diagnostics has provided the requested information.