

# TEST FOR VIRUS INC.

## Authorization for Use and Disclosure of Protected Health Information

I hereby authorize TEST FOR VIRUS INC. to use and/or disclose my protected health information as described below to

(name and address of recipient) \_\_\_\_\_

for the following purposes: (describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)

I understand that:

- 1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
- 2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
- 3) I may revoke this authorization at any time by notifying TEST FOR VIRUS INC. in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
- 4) TEST FOR VIRUS INC. agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

### Marketing:

If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

### Type of Information to Be Disclosed

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Most Recent 5 Year History             | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Office Chart Notes    | <input type="checkbox"/> All Hospital Records                   | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Billing Statements    | <input type="checkbox"/> Transcribed Hospital Reports           | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Dental Records        | <input type="checkbox"/> History and Physical Exam              | _____                                      |
| <input type="checkbox"/> Laboratory Reports    | <input type="checkbox"/> Emergency and Urgent Care Records      | _____                                      |
| <input type="checkbox"/> Pathology Reports     | <input type="checkbox"/> Medical Records for Continuity of Care |  |
| <input type="checkbox"/> Consultation          | <input type="checkbox"/> Diagnostic Imaging Reports             |  |
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Emergency Room Reports                 |  |

In addition, I authorize that this will include health information relating to (check if applicable):

HIV/AIDS infection       Drug/Alcohol abuse       Genetic Testing

### Expiration:

This authorization will expire 180 days from the date of signing or (insert date) \_\_\_\_\_.

Patient Name: \_\_\_\_\_ Patient ID #: \_\_\_\_\_

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Patient's Representative (if applicable) \_\_\_\_\_  
 Parent or guardian of unemancipated minor  
 Court appointed guardian  
 Executor or administrator of decedent's estate  
 Power of Attorney

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_