



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

I authorize Quest Diagnostics to use and/or disclose protected health information (which may pertain to my diagnosis and treatment, laboratory test results, medical history, billing information, ordering and treating physicians, and other related information, including but not limited to HIV and drug testing information) 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 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 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.
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.

Patient's Information (#1-3 are required):

1. Patient's Name (First Name, Middle Name, Last Name) 2. Date of Birth (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) 10. Ordering physician's address 11. Ordering physician's phone number

Signature:

I have reviewed and I understand this Authorization.

Name (print)

Signed: (Patient) Date:

Or By: (Patient's Representative) Date:

Description of Representative's Authority

This authorization will expire on: (MM/DD/YYYY) (or) after the following event:

Quest Diagnostics Incorporated

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 Incorporated
Auburn Hills
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