Sonora Quest Laboratories™
A Subsidiary of Laboratory Sciences of Arizona

# Authorization to Use or Disclose Protected Health Information (PHI)

**PATIENT IDENTIFICATION – PLEASE PRINT LEGIBLY**

**Name** _____

**Address** _____

_____

**City** **State** **Zip**

**Phone** _____ - _____ - _____

**Date of Birth** ____ / _____ / _____

**Approximate Date(s) of Service**___ /___ /___

**Dr./Office Name** _____

**INFORMATION REQUESTED / DELIVERY REQUIREMENTS – MUST CHECK A BOX**

**Send results via:** ☐ **Secure fax:** _____ ☐ **Mail to address above**

☐ **Secure email (enter in boxes below):** ☐ **Mail to address below**

**Complete ONLY if requesting results via email:**

☐ **Send results encrypted** ☐ **Do not send results encrypted**

***Unencrypted information sent via email can be intercepted by unauthorized parties***

**INFORMATION TO BE DISCLOSED TO:**

_____ _____ - _____ - _____

**Company, Person, Facility** **Phone Number (Including Area Code)**

_____ _____ _____ _____

**Street Address** **City** **State** **Zip**

Sonora Quest Laboratories relies on information provided by the physician at the time the laboratory test is ordered. The information provided by the physician may not be sufficient to accurately match the information you provide on this form. In such cases, Sonora Quest Laboratories will protect our patient's privacy by *not* releasing results that do not conform to our strict criteria for determining matches. Failure to provide all information we request may prevent us from identifying some of your records.

I understand that information in my health record may include information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing. My signature authorizes release of such information.

I may refuse to sign this authorization form. I understand that Sonora Quest Laboratories will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.

Unless I revoke this authorization earlier**, it will expire six (6) months from the date signed or on ___/___/___.**

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Sonora Quest Laboratories, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

**Signature of Patient** **Date**

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

_____ _____

**Signature of Legal Representative** **Relationship to Patient or Description of Authority to Act for Patient**

**Completed forms may be mailed, scanned and emailed, faxed, or dropped off at any of our Patient Service Centers**

*Internal use only:*
*Date received:*_____
*Tracking #:*_____
_____

**Sonora Quest Laboratories**
**ATTN: HIMS Department**
**424 S. 56th St., Ste. 100**
**Phoenix, AZ 85034**

**Fax to: 602.685.5553**
**Email to:**
**DTP-Arizona@SonoraQuest.com**