MHS LABS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize MHS Labs to release information:

Patient Name	Birth Date	Last 4 digits SSN	as described below to:

Facility/Person to Receive Records	Phone	FAX

Mailing address of facility or person to whom records are to be released:

Street	City	State	Zip Code

A. Records are requested for the purpose of: ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance
(*Please check one):* ☐ Other:_____ ***Note: Purpose is not required for patient access.***

B. Disclosure Format ☐Paper ☐ FAX (Providers Only)_____ ☐ Other:_____

Method Received ☐ US Mail ☐ In-Person Pickup ☐ FAX (Providers Only) *(fax number):* _____
☐ Email:_____ ☐ Direct Address:_____

C. Parts 1 and 2 below must be completed to properly identify the records to be released.

1. <u>Type of records to be released and date(s) of service (check all that apply):</u>
☐ Outpatient – Dates:_____ ☐ Other _____

2. <u>Specific information to be released (check all that apply):</u>

☐ Laboratory Report/Test
☐ Covid Testing for Exposure/Symptomatic
☐ Covid Testing for Travel

☐ Other, specify: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ Do not release

I understand that this Authorization is effective for a period of 6 months from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **<u>See side two of this form for additional patient rights and responsibilities</u>.**
If applicable, specify other expiration date/event here: _____

Date of Signature	Signature of Patient (14 years of age or older) may authorize release of outpatient testing information from a licensed facility. A minor can authorize release of testing for STDs or testing related to pregnancy from a licensed facility.	Date of Signature	Signature of Authorized Representative

Appropriate paperwork required :
☐ Parent or Legal Guardian (copy of guardianship order attached)
☐ Power of Attorney (copy attached)
☐ Next of Kin of Deceased (copy of death certificate attached)
☐ Executor of Estate (letter of administration or testamentary attached)

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information
I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date	Witness #1	Date	Witness #2

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Additional Patient Rights and Responsibilities

Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records. I understand that it is possible that the facility/person that received the records may re-disclose the information, therefore 1) MHS Labs and its affiliates, and their respective staff/employees have no responsibility or liability as a result of any re-disclosure and, 2) such information would no longer be protected by the Privacy Rule.
- I understand and authorize the release of records to the individual referenced herein using non-encrypted electronic media. I understand and agree that neither MHS Labs nor its affiliates, nor their respective staff/employees have any responsibility or liability if the protective health information is breached due to the media not being encrypted or being accessed by an unauthorized individual.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical testing and I understand that I may be responsible for payment of the claim.
- I understand that I am not required to sign this Authorization in order to receive treatment.
- In accordance with 4 PA Code 255.5 (b), Drug and Alcohol treatment information to be released to judges, probation or parole officers, insurance companies, health or hospital plan(s) or governmental officials shall be restricted to the following:

    1. Whether the client is or is not in treatment.
    2. The prognosis of the client.
    3. The nature of the program.
    4. A brief description of the progress of the client.
    5. A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

- I am entitled to a copy of this completed Authorization form.

Office use only:

☐ **Identity verified by Photo ID**

Individual releasing records:

Print Name Clearly: _____

Initials: _____Date_____