

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____
(Please print or type)

Date of Birth: _____

ID Number: _____

I authorize Forensic Fluids Laboratory, LLC ("FFL"), to use or disclose my protected health information as described below.

Specific Information I authorize to be used or disclosed:

- All (entire laboratory record) Initial _____
- Alcohol/Substance Abuse Initial _____
- Genetic Testing Initial _____
- Other (please specify, including dates of treatment):

Organization(s) or Person(s) FFL is authorized to release my information to:

Purpose(s) of the use or disclosure:

- At the request of the patient
- Other (please specify):

I understand the following:

Any information used or disclosed because I have signed this authorization may no longer be protected by privacy laws and may be subject to re-disclosure by the person or organization receiving it.

I have a right to revoke this authorization at any time by doing so in writing and presenting my written revocation to the Privacy Officer of FFL.

Any request to revoke this authorization will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Any request to revoke my authorization will not apply to the extent FFL, has taken action in reliance upon my authorization.

I may refuse to sign this authorization and you will not condition treatment based upon my providing a signature on this authorization unless it is for research-related treatment or the provision of care for the sole purpose of creating information for a third party. If I refuse to sign in either of these two instances, I understand that you may refuse to treat me.

I may inspect or copy any information to be used or disclosed based upon this authorization.

If this authorization is for marketing purposes and you will receive compensation from a third party for use or disclosure of my information, this box will be marked .

This authorization expires on _____, 20____, or upon the event of _____.

If no date or event is stated above, this authorization shall expire 6 months after the date of execution.

Signature of Patient (or Personal Representative)

Date

Personal Representative's Printed Name and Relationship to Patient

IMPORTANT NOTICE: ANY INFORMATION PROTECTED BY FEDERAL REGULATIONS GOVERNING SUBSTANCE ABUSE TREATMENT (42 CFR, PART 2) IS PROHIBITED FROM FURTHER DISCLOSURE UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.