



## HIPAA Compliance Patient Consent Form

I authorize \_\_\_\_\_ (healthcare provider) to use and disclose the protected health information described below to TRILAB LLC.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

2. I authorize the disclosure and/or use of any information, including medical information, laboratory results and medical opinions, relating to the specimen(s) collected from me on \_\_\_\_\_ (date).

3. I authorize the disclosure and/or use of any information, including medical information, laboratory results and medical opinions for employment purposes.

4. This authorization shall be in force and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

By signing this form, I understand that:

- Protected health information may be disclosed or used for employment purposes.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we send your results via fax? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

\_\_\_\_\_

This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_