

Authorization for Use or Disclosure of PHI Form

Please read carefully and complete the reverse side of this form.

Except disclosures for treatment, payment or healthcare operations, all sections of this authorization must be completely filled out before Prometheus is permitted to disclose your protected health information.

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Prometheus Laboratories Inc. (“Prometheus”) will still provide medical treatment if you do not sign this authorization, except under limited circumstances that are described in our Notice of Privacy Practices. **Please be aware that once your information leaves Prometheus, Prometheus will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.**

NOTICE TO OCCUPATIONAL MEDICINE PATIENTS: Your state law may allow your employer to access your health records only if you authorize the disclosure in writing, or for certain specific reasons. Some of the reasons include situations when your employer is required to do so by law; when you’re involved in a lawsuit (or similar process) with your employer and your medical history is at issue; when the information requested was requested or paid for by your employer; when the information is required to evaluate your need for medical leave or disability related benefits; or when it is necessary to administer your employee benefits plan. If you have questions or concerns about whether any of the above situations apply to you, please notify your provider before beginning any procedure and consider notifying your employer.

RESTRICTIONS: I understand that Prometheus may not further use or disclose the information described on the reverse side of this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Prometheus from any/all liability that may arise from the release of this information to the party named on the reverse side of this form.

ADDITIONAL COPY: I further understand that I or my authorized representative has a right to receive a copy of this authorization upon my request.

DURATION: I understand that I or my authorized representative may revoke this authorization in writing at any time, except to the extent that action has already been taken, by writing to:

Prometheus Laboratories Inc.
Attn: Client Operations
9410 Carroll Park Dr.
San Diego, CA 92121
Fax: (877) 816-4019

Unless otherwise noted, this authorization will expire *one year* from the date of signature.

1. **Authorization:** I authorize the disclosure of PHI and/or billing records as described below:

Name of Patient: _____

Date of Birth: ____/____/____ Telephone: (____) ____-____

2. **Record Holder's Name:** _____ Prometheus Laboratories Inc.

Address: 9410 Carroll Park Drive City: San Diego State: CA Zip: 92121

3. **Records Released To:** _____ Physician #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

4. **Information to be Released for these Dates of Service:** From _____ To _____

5. **Description of Information:** Initial each category of information to be released:

Billing Information Laboratory Tests Reports Other (Please Specify):

6. **Use of Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please initial all that apply.**

Continuing Medical Care Second Opinion Legal

Personal Insurance Other (please specify):

7. **Mailing Instructions:** Please mail/fax **both sides** of this authorization form to:

8. **Expiration Date** (if sooner than 1 year): _____

9. **Signature:**

Print Name: _____ Signature: _____

Date/Time: _____ Relationship to Patient: _____

If you are not the patient, indicate your legal authority to sign on behalf of patient (parent, HIPAA representative, Healthcare Power of Attorney, etc. and **attach specific documentation**): _____