# HIPAA AUTHORIZATION FOR USE ORDISCLOSURE OF HEALTH INFORMATION

**The Phleb Mobile Phlebotomy Services** - Santa Barbara CA, DATE: _____, 20_____.

I. **I, THE PATIENT** Understand this form is for use when such authorization is required and complies with the Health Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

**Patient Name:** _____**DOB**: _____

**Address:** _____

**II**. **AUTHORIZATION.** I authorize _____ to disclose the following information:

☑ **X - LABORATORY ORDER OR REQUISITION FOR MOBILE LABORATORY SPECIMEN COLLECTION PURPOSES FROM ORDERING PROVIDER. DR.**_____

**III. DISCLOSURE.** The authorized party has my authorization to disclose and/or provide **Laboratory Requisition** or **Lab Order** to: **Company:** The Phleb Mobile Phlebotomy Services

**Contact Name:** *Juan Cambron Perez, CPT*

**Address:** 629 State St Suite 230 Santa Barbara CA 93101

**Phone**: (805)951-8577 - FAX: **(805)410-9584**

**Email**: ThePhlebServices@gmail.com

**IV. PURPOSE.** The reason for this authorization is:

Please Fax or Secure Email Lab Order

☑ **X** – **GENERAL PURPOSE**. At my request - REQUIRED LABORATORY ORDER TO PERFORM AT HOME BLOOD DRAW/ MOBILE PHLEBOTOMY SERVICES

**V. TERMINATION.** This authorization will terminate on **DATE**: _____

**VI. ACKNOWLEDGMENT OF RIGHTS.**

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original. This "medical record" may contain sensitive protected information about your personal health (Diagnosis, Treatment, STI/HIV, bloodborne, Airborne, contact precautions, droplet precautions, etc).

**Print Name:** _____

**Signature of Patient:** _____**Date:** _____
Or Guardian