WesternU Health
Oral Pathology Laboratory

Authorization for release and disclosure of health information (1/2)

☐ I request and authorize WesternU Health Oral Pathology Laboratory to release health information from WesternU Health Oral Pathology Laboratory to the person/entity below. I am aware that shipping and/or replacement fees may be applied.

PATIENT INFORMATION

Patient name *(Please print.)*
____

Date of birth (MM/DD/YYYY) Age Sex
____

Address
____

City State Zip
____

Home telephone Mobile telephone
____

SEND HEALTH INFORMATION TO

Name of person or facility to release health information to:
____

Specify name/title of person to receive health information, if known
____

Address
____

City State Zip
____

Telephone Fax
____

NATURE OF HEALTH INFORMATION

Please check all patient records that you authorize WesternU Health Oral Pathology Laboratory to release and disclose. Pathology case materials will be sent by mail to the person/entity listed above.

☐ Pathology report(s) Specimen/lab no. ______________________________

☐ Microscopic slide(s) Specimen/lab no. : ______________________________

☐ Other: ______________________________

SPECIFIC AUTHORIZATIONS

The following patient information will not be released unless you specifically authorize disclosure by checking box(es) below.

☐ I specifically authorize the release and disclosure of information pertaining to drug and alcohol abuse, diagnosis, or treatment (42 C.F.R. §§ 2.34 and 2.35).

☐ I specifically authorize the release and disclosure of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§ 5328, *et seq*.).

☐ I specifically authorize the release and disclosure of HIV/AIDS test results. (Health and Safety Code § 120980 (g)).

☐ I specifically authorize the release and disclosure of genetic testing information. (Health and Safety Code § 124980 (j)).

PURPOSE OF RELEASE: CHECK ONE OR MORE

☐ Continuity of care or discharge planning

☐ Billing and payment of bill

☐ At the request of the patient/patient representative

☐ Other (state reason) ______________________________

MUST COMPLETE BACK PAGE!

Authorization for release and disclosure of health information (2/2)

NOTICE
WesternU Health Oral Pathology Laboratory any many other organizations and individuals such as dentists, physicians, hospitals, and health benefits are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

☐ I understand this authorization is voluntary. Treatment, payment enrollment or eligibility benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

☐ I may revoke this authorization at any time, provided that I do so in writing and submit it to WesternU Health Oral Pathology Laboratory c/o Lab Director, 701 E 2ND St Rm 3204 Pomona, CA 91766. You may also fax your request to 909.469.8650. The revocation will take effect when WesternU Health Oral Pathology Laboratory receives it, except to the extent that WesternU Health Oral Pathology Laboratory or others have already relied on it.

☐ I am entitled to receive a copy of this authorization form.

EXPIRATION OF AUTHORIZATION

☐ Unless otherwise revoked, this authorization expires ____________________________ (insert applicable date or event).

☐ If no date is indicated, this authorization will expire 12 months after the date of signing this form.

SIGNATURES

Signature of patient or patient's legal representative

____

Date

____

Printed name

____

Time

AM/PM
____

If signed by someone other than the patient,
state your legal relationship to the patient/authority

____

Witness or translator

____

MAIL FORM WITH ORIGINAL SIGNATURE TO:

WesternU Health Oral Pathology Laboratory
c/o Laboratory Director
701 E 2ND St Rm 3204
Pomona, CA 91766

WesternU Health Oral Pathology Laboratory
Please return requested material if requested. Please note that any loss or damage to the requested specimen/tissue material released by WesternU Oral Pathology Laboratory may limit or prevent adequate diagnostic use.