PhysLab®

www.physlab.com

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402-488-7710
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RELEASE OF MEDICAL RECORDS

Patient Last Name: _____ First: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

By signing below I authorize Physicians Laboratory Services, Inc. and/or Physicians Laboratory P.C. to release the following information from my medical records to the party indicated: (check the appropriate box)

☐ Results ☐ Billing Statements ☐ Other: _____

My information, as designate below, may be inspected and/or released to the following:

☐ Myself ☐ Other (Please Indicate Name): _____

Information should be sent to the designated individual listed above via the following method:

Fax: _____
(Indicate Fax Number)

Email: _____
(Indicate Email Address – See Reverse Side for Important Information)

Mail: _____
(Indicate Street Address, City, State, and Zip)

I may revoke this authorization in writing at any time (Please Note: Physicians Laboratory will not be able to honor the revocation if the previously requested actions have already been carried out). Unless revoked or renewed in writing, this authorization will expire **ONE YEAR** from the date it was signed.

_____
(Patient's signature) (Date)

********The patient is a minor (under the age of 19), subject to guardianship or is deceased, I have signed my name below on behalf of the patient (must show proof) :

_____
(Patient's Legal Guardian's or Agent's Signature) (Date)

Please see reverse side for information regarding release of medical records and utilization of email to communicate protected health information.

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RELEASE OF MEDICAL RECORDS (CONTINUED)

The following people are authorized to sign for release of information:

1. The patient (Not the spouse.)
2. Power of attorney if patient is unable to sign (Document must be provided.)
3. Parent (If the patient is under the age of 19.)
4. Parent and minor (If the patient is 12-18years of age, this is for records relating to substance abuse testing.)
5. Legal guardian (Proof of guardianship document must be provided.)
6. Representative of the state for deceased patients (Copy of the death certificate and a copy of the representative of estate documents ***MUST*** be provided.)

UTILIZING EMAIL TO COMMUNICATE PROTECTED HEALTH INFORMATION

Physicians Laboratory utilizes Zix Email Encryption to help secure protected health information. The email you receive may be delivered with a notification:

This message was sent securely using ZixCorp.

Follow the instructions to login to the secure website and retrieve your email

NOTE: Physicians Laboratory Services Inc. / Physicians Laboratory P.C. may not be able to encrypt all email messages. Encryption is the process of making information unreadable unless you have the password or key to de-crypt the information. We have the ability to encrypt some email communications that contain protected health information and will encrypt email communications when possible.

We want to make sure you know that un-encrypted email is not a secure communication. When Physicians Laboratory sends email there is a risk that the information included in the email, and its attachments, may not be encrypted. This means that there may be some level of risk that the information in the email could be read by a third party. Also, email communications may become a part of your medical record and accessible to our staff as needed for our operations.

In addition, once an email is received by you, Physicians Laboratory is no longer responsible for safe guarding that information. If you elect to communicate from your workplace computer, you should be aware that your employer and its agents may have access to the email communications between us.