ARUP LABORATORIES | NATIONAL REFERENCE LABORATORY

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www.aruplab.com

Authorization to Release ARUP Testing Records

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Full Name (and/or alias)

Date of Birth (MM/DD/YYYY) **Phone # (include area code)** **Ordering Facility**

Patient Address

Date(s) of Treatment (The treatment episode must have already occurred.)

1. I authorize the following facility to **DISCLOSE** my patient information:

Name: ARUP Laboratories, INC
Address: 500 Chipeta Way, SLC, UT 84108

2. I authorize the following person or organization to **RECEIVE** my patient information:

Name **Phone #**

Address

3. Please disclose the following information pertaining to a diagnosis or event (check to indicate your selection):

❑ Lab reports ❑ Other: _____

4. Please describe the purpose of the disclosure. The purpose must be specific to the request and not for future unspecified treatment.

5. I understand that if the authorized recipient of this information is not a healthcare provider or health plan covered by federal privacy regulations, the information he/she/it receives will no longer be protected by these regulations, and the recipient may redisclose the information. However, the recipient may be prohibited from disclosing substance abuse records from a federally funded substance abuse treatment program.

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6. I understand that ARUP Laboratories will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

7. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: ARUP Laboratories Privacy Officer MS241, 500 Chipeta Way, Salt Lake City, Utah 84108.

   I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires 90 days from the date I sign below

_____ _____

Signature of Patient or Representative **Date**

_____

Patient Name **Name of Personal Representative (if applicable)**

_____

If signing as personal representative, describe authority to act for patient and submit documentation showing such authority such as power of attorney.

_____

(Notarization is required.)

Subscribed and sworn before me this _____ day of_____, 20_____.

_____

Notary Public

_____

Residence

_____

Date commission expires

_____

Please submit completed form (and any proof of representation, if applicable) to:

ARUP Laboratories, INC
Attn: Privacy Officer MS241
500 Chipeta Way
Salt Lake City, UT 84108

OR fax to; (801) 584-5108

(This signature page authorizes the release of testing records from ARUP Laboratories, INC.)