Sarah Bush Lincoln

DATE OF SBL COVID LAB TEST: _____

TO: ☐ Sarah Bush Lincoln Health Center ☐ Physician Clinic _____

Patient Name: _____ Date of birth ____/____/____
xx / xx / xxxx

Address: _____
(address) (City, State) (Zip Code)

Contact Phone #: _____

You are hereby authorized to release the COVID Lab Test result to: (Who the protected health information is going to)

Name: _____

Address: _____
(address) (City, State) (Zip Code)

Contact Phone #: _____

Relationship to Patient: _____

Method of Release: ☐ **Mail Copy** ☐ **Pick Up Copy** ☐ **Fax Copy** **Fax #** _____

I am signing freely and with full knowledge and understanding. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure if the recipient(s) as described on this form is not required by law to protect the privacy of the information. This authorization expires upon completion of this request.

Signed _____ **Date** _____ **Time** _____
(Patient or Legal Representative)

If Legal Representative, document relationship to Patient: _____

Signed _____ **Date** _____ **Time** _____
(Witness)

For Office Use Only: Medical Record # _____ Encounter # _____

Effective Date: 7/21/20
240033

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION COVID LAB TEST

Clinic Scan to: HIPAA Privacy Documents

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