Trumbull Laboratories, LLC and Pathology Group of the Midsouth, PC

Form: Authorization for Release of Medical Records/ Protected Health Information

For information about how your medical records or protected health information (collectively, "PHI") may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of this notice from Trumbull Laboratories, LLC and Pathology Group of the Midsouth, PC ("TL/PGM"). The Notice is also posted on TL/PGM's website and at TL/PGM's office.

- **YOU HAVE THE RIGHT TO INSPECT, COPY, AND/OR AMEND PHI TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGH THIS FORM; HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED (such as enrollment in research study or examining you to create a report for your attorney).**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.**
- **WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

THIS AUTHORIZATION IS VOLUNTARY

I, _____, (date of birth: _____), do hereby authorize TL/PGM to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my PHI and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse that the released information may no longer be protected by federal privacy regulations.

Attention: choose one of the following options and initial the choice

_____Complete Medical Record that may contain treatment notes or references regarding radiology, pathology (including AIDS or HIV test results and genetic testing information), immunizations, procedure(s), alcohol and drug abuse records protected by federal Confidentiality rules 42 CFR Part 2, Psychiatric and social information, medical records obtained from hospitals and other doctors, and other common medical record documentation made by the physician, nurse or other ancillary personnel for the entire time I received service from the practice.

_____Complete Medical Record, as described above, during the dates: _____ to _____.

These records are to be sent from TL/PGM to _____for the purpose of _____
_____.

I understand that I may withdraw my authorization in writing to the Privacy Officer of TL/PGM at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire one (1) year from this date. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to these persons or agencies listed above. A copy of this authorization may be utilized with the same effectiveness as the original.

_____ _____
Signature of Patient or patient's representative Date

_____
Printed Name of Patient's Representative

Description of the Representative's authority to act for the patient: _____
_____