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

AUTHORIZATION TO DISCLOSE PHI TO FRIENDS / FAMILY

For additional information about how your medical information may be used or disclosed, please see the Notice of Privacy Practices.

- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED (such as 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**

THIS AUTHORIZATION IS VOLUNTARY

By my request, I hereby authorize Trumbull Laboratories, LLC and Pathology Group of the Midsouth, PC ("TL/PGM") to disclose information regarding my treatment, insurance issues and payment issues to the people listed below:

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that this authorization is voluntary. I understand that the person to whom I authorize disclosure of my personal data is not a health plan, health care provider, or clearinghouse and that the released information, in their possession, may no longer be protected by federal privacy regulations. 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 have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about my condition to those persons or agencies listed above.

_____ _____
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

_____

Relationship to patient _____