DOCTOR'S ORDERS MOBILE COLLECTION SERVICES, LLC
Bradenton, Florida
Call or text: (941) 531-1636
getmyblood.com | hello@getmyblood.com

Authorization for Release of Protected Health Information

Complete, sign, and return before your appointment. Valid for one year from the date signed.

1 PATIENT INFORMATION

Patient full legal name _____ **Date of birth** _____

Street address _____ **Phone** _____

City, State, ZIP _____ **Email** _____

2 WHO MAY RELEASE MY INFORMATION

I authorize the following to disclose my protected health information as described in Section 4:

Ordering provider / practice _____ **Phone** _____

Provider address _____ **Fax** _____

Laboratory (Quest, LabCorp, other) _____ **Lab location** _____

■ I also authorize release from any other treating provider or laboratory I identify in writing to Doctor's Orders Mobile Collection Services, LLC during the term of this authorization.

3 WHO MAY RECEIVE MY INFORMATION

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Including its owner, employees, and authorized agents acting on its behalf.

4 WHAT INFORMATION MAY BE RELEASED

- ■ **Laboratory orders and requisitions.** Tests ordered, diagnosis codes, ordering provider information, and special collection instructions such as fasting or timing requirements.
- ■ **Laboratory results.** Results for specimens collected by Doctor's Orders, including reports of rejected, insufficient, hemolyzed, or otherwise unusable specimens.
- ■ **Specimen and collection status.** Whether a specimen was received, processed, or requires recollection.
- ■ **Scheduling and demographic information.** Only as reasonably necessary to complete the collection.

Purpose. To allow Doctor's Orders Mobile Collection Services, LLC to obtain my laboratory orders, perform specimen collection, deliver specimens to the correct laboratory, confirm the specimen was accepted, and arrange recollection if a specimen is rejected or a test must be repeated.

Not included unless initialed. This authorization does not cover psychotherapy notes. It also does not cover records relating to HIV/AIDS testing, mental health treatment, substance use disorder treatment, sickle cell trait, or genetic testing unless the patient initials here: _____

5 TERM, EXPIRATION, AND RIGHT TO REVOKE

This authorization takes effect on the date signed and **expires one (1) year from that date**, unless I revoke it sooner in writing.

Effective date _____ **Expiration date** _____

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I may revoke this authorization at any time by written notice to Doctor's Orders Mobile Collection Services, LLC, including by email to hello@getmyblood.com. Revocation takes effect when received and does not apply to any disclosure already made in reliance on this authorization.

6 ACKNOWLEDGMENTS

1. **Redisclosure.** Once disclosed to Doctor's Orders Mobile Collection Services, LLC, my information may no longer be protected by federal privacy regulations and could be redisclosed. Doctor's Orders agrees not to redisclose my information except as necessary to carry out the purpose stated in Section 4, or as required by law.
2. **Voluntary.** Signing is voluntary. Doctor's Orders may be unable to retrieve my lab order on my behalf if I do not sign, because it cannot legally obtain that order without my authorization. My treatment by my own physician, my payment, and my health plan enrollment are not conditioned on signing.
3. **Copy.** I am entitled to a copy of this signed authorization, and one will be provided to me.
4. **Fees and insurance.** Mobile specimen collection provided by Doctor's Orders Mobile Collection Services, LLC is not covered by insurance and is billed as a flat out-of-pocket fee. Laboratory testing itself is billed by the laboratory to my insurance in the normal course.

7 SIGNATURE

Patient signature _____ **Date** _____

Printed name _____ _____

If signed by a personal representative

Representative signature _____ **Date** _____

Printed name _____ **Relationship** _____

Legal authority (parent, guardian, healthcare surrogate, POA) _____ _____

Office use. Retain the signed original. Provide a copy to the patient. Store in HIPAA-compliant storage only. Return this form by handing it to your phlebotomist, texting a photo to (941) 531-1636, or emailing hello@getmyblood.com.

Email and text message are not fully secure. By returning this form by email or text you accept that risk. You may hand a signed paper copy to your phlebotomist instead.