Patient Account Number _____
State Where Service was Rendered _____

Pathology Service Associates, LLC
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person or entity authorized to receive the information is not a healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Social Security No.: _____ Date of Birth: _____

Person/entity authorized to receive the information: _____
Mailing Address: _____

Specific description of information (including dates): _____
_____
_____

The purpose of the use or disclosure is: _____
_____

Will the person or entity requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

Yes _____ No _____

- I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
- I understand that this authorization will expire on _____ or 1 year from signature date or period as specified by state law, whichever date occurs first.
- I understand that I may revoke this authorization at any time by notifying PSA in writing. I also understand that if I revoke this authorization, the revocation will not have any effect on actions taken by PSA before PSA received the revocation. I also understand that more information regarding revocation of this authorization may be covered in PSA's Notice of Privacy Practices.

Initials _____

_____ _____
Signature of Patient or Patient's Legal Representative — Date

_____ _____
Printed Name — Relationship of Legal Representative to Patient