Authorization for Disclosure of Protected Health Information

For all uses and disclosures of a patient's Protected Health Information ("PHI"), other than those required by law or for treatment, payment and health care operations, The Health Insurance Portability and Accountability Act ("HIPAA") requires that Abbott obtain an authorization that is signed by the patient. The purpose of obtaining an authorization is to provide the patient with an opportunity to determine how PHI may be used or disclosed, and to inform the patient of rights under HIPAA.

I, _____(patient or personal representative) authorize and request Abbott to disclose the below-specified PHI of:

Name _____

Address_____

City/State/Zip_____

Telephone _____Date of Birth _____

The specific information to be disclosed is:

☐ The entire Designated Record Set ("DRS") in Abbott's possession

☐ Specific portions of the DRS in Abbott's possession as indicated below:
Portions to be disclosed:
_____

For services from _____ to _____
(date) *(date)*

Disclose specified information to the following entity or individual:

_____
(name of indicated entity or individual to receive protected health information)

_____
(address)

_____
(city, state, zip)

Information is being disclosed for the following purpose(s):

_____

1. This authorization becomes effective on _____.
This authorization automatically expires on the following date, event or special condition: _____.
If I fail to specify an expiration date or event, this authorization will expire in one year.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so IN WRITING and present my written revocation to Abbott's Privacy Officer. I further understand that actions already taken based on this authorization, prior to revocation, will NOT be affected.
3. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original**.
4. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by Federal confidentiality rules.

I understand that my health information is confidential and that by signing this authorization, I am allowing the release of my Protected Health Information. **My signature below acknowledges that I have read, understand and authorize the release of my PHI.**

Name of Patient or
Personal Representative *(PLEASE PRINT)* _____

Signature of Patient or
Personal Representative: _____ Date:_____
(If Personal Representative, include a description of authority to act for patient)

Signature of Witness: _____ Date:_____

Please submit this form directly to: Privacy Officer: E-mail: ARDx_PrivacyOfficer@Alere.com Toll-free: 866-943-6964 Fax: 913-234-4539 Abbott 2900 Delk Road, Suite 700, PMB 301 Marietta, GA 30067-5350. If you have any questions, please contact the Privacy Officer via email at: ARDx_PrivacyOfficer@Alere.com

NOTICE OF REVOCATION

I, _____(patient or personal representative) hereby revoke my authorization of this disclosure of my PHI to the entity/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization prior to revocation will not be affected.

Name of Patient or
Personal Representative *(PLEASE PRINT)* _____

Signature of Patient or
Personal Representative: _____ Date: _____
(If Personal Representative, include a description of authority to act for patient)

Signature of Witness: _____ Date:_____

Please check appropriate Company below:

☐Alere Toxicology ☐Acelis Connected Health Services ☐Acelis Connected Health Supplies ☐Redwood Toxicology