UCSF CLINICAL LABORATORIES

FAX VERIFICATION FORM

Tests ordered under this account will be resulted by fax. Authorize results reporting by completing the form below.

The undersigned Client hereby authorizes **UCSF Clinical Laboratories** to send Protected Health Information (PHI) as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA, 45 C.F.R. Parts 160-64), to the following fax number(s) to the extent such transmission is determined by **UCSF Clinical Labs** to be a necessary component of the professional business relationship between **UCSF Clinical Labs** and the Client.

List the fax number where **UCSF Clinical Lab** results should be transmitted.

Primary/Laboratory Fax Number: _____

Client represents to the **UCSF Clinical Labs** that Client has implemented appropriate policies and procedures, including physical safeguards, to ensure that the location of, access to and use of Client's fax machine complies with state and federal laws and regulations controlling the privacy of PHI including, but not limited to, HIPAA.

This Authorization will remain valid until revoked or changed by Client.

Institution Name: _____

Address: _____

_____

Authorized Approver:

Signature:_____ Date:_____

Printed Name:_____ Title/Position:_____ Phone:_____

Change or revoke Fax Authorization:
Client must provide written notice to **UCSF Clinical Labs** at least five days prior to the implementation of the requested change or revocation. Notices may be faxed to **UCSF Clinical Labs** (415) 353-9486, or mailed to:UCSF Medical Center, Clinical Laboratories, Attn. Laboratory Director, Box 0100, 505 Parnassus, San Francisco, CA, 94143.