Authorization to Access/Use/Disclose Protected Health Information

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

NOTE: There may be a fee for production of the medical records.

Information requested in this Authorization is based on requirements by both state and federal regulations.

You may attach an additional page if more room is needed than provided on the request form. If you are requesting records for a deceased patient, please submit a copy of the death certification; copy of Power of Attorney, trust or will, if available; driver's license of person requesting medical records; along with the completed request form.

Please forward this form, for Incyte Pathology maintained records ONLY to:

Incyte Pathology
Attn: HIPAA Privacy
PO Box 3405
Spokane, WA 99220-3405
Email: legal@pacc.inc
Phone: 509-508-4519 | Fax: 509-342-2743

Please Note:

If your laboratory services were provided in a hospital setting, those records may be maintained by the hospital.

Billing records for Professional Analytics may be requested; however, all other medical records are maintained by the hospital who provided the clinical laboratory services to you.

For services provided after 12/8/2025 contact Labcorp recordsrequests@labcorp.com

PATIENT REQUEST TO ACCESS/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization is requested to comply with state and federal regulations.

Patient's Name:	Date of Birth:	
Prior Name(s) Used:	Phone#:	
Patient's Address:		
City:	State:	Zip Code:
Email Address: @		

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Incyte Pathology to release my medical records to: ◯ Myself OR ◯ Recipient below:

Recipient's Name:	Date of Birth:	
Recipient's Address:		
City:	State:	Zip Code:
Phone Number: Fax:		
Delivery Option: ◯ Fax ◯ Paper (Mailed) Email: _____ @ _____		
NOTE: Email delivery will be encrypted to protect your information.		

INFORMATION TO BE RELEASED

Date(s) of Services for Records being requested _____ (not valid for future dates)

◯ Pathology Report(s) ◯ Consultation Report(s)

◯ Itemized Billing Statement ◯ Explanation of Benefits ◯ HCFA 1500

Other:_____

ADDITIONAL AUTHORIZATION REQUIRED WHEN RELEASING RECORDS TO INDIVIDUALS OTHER THAN THE PATIENT

I specifically authorize release of the following information: (CHECK, INITIAL AND DATE)

◯ HIV Status	Initial and Date:
◯ Alcohol/drug treatment information	Initial and Date:
◯ Sexually Transmitted Disease	Initial and Date:

PURPOSE

Purpose of requested use or disclosure: ◯ Patient Request ◯ Continuing Care

◯ Legal ◯ Insurance ◯ Other: _____

EXPIRATION

This authorization expires:_____

If no date is given, this authorization will expire in six months from the date of signature.

YOUR RIGHTS

You may refuse to sign this authorization. If you refuse to sign this authorization, by law, your health information cannot be released. Your refusal will not affect your ability to obtain treatment, payment or eligibility benefits.

You may revoke this authorization at any time, but it must be done in writing and submitted to the following Address:

Incyte Pathology
Attn: HIPAA Privacy Officer
PO Box 3405
Spokane Valley, WA 99220-3405

Your revocation will take effect upon receipt, except to the extent that others have acted in reliance of this authorization.

You have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is not always covered by state law and may no longer be protected by federal HIPAA laws.

SIGNATURE (typed signature not accepted)

Patient Signature:	Date:
Legal Representative Signature: (Patient Rep./Spouse/Parent)	Date
Relationship to Patient:	

If signed by someone other than the patient, state your legal relationship to the patient and please provide a copy of support documentation (i.e. power of attorney, death certificate, guardianship appointment).

FOR OFFICE USE ONLY

Delivery Format: ◯ *Email* ◯ *Mail* ◯ *Fax* ◯ *Other*_____

*Date Request Fulfilled:*_____

*Fulfilled by:*_____