LAB-IN-A-BOX® FACSIMILE/PRINTER VERIFICATION FORM

The undersigned Client hereby authorizes Home Healthcare Laboratory of America (HHLA) to send Protected Healthcare Information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160-64) to the following printer/facsimile phone number(s) to the extent such transmission is deemed by HHLA to be reasonably necessary as part of the professional business relationship between HHLA and Client:

Facsimile number: ____
(Please fill in the facsimile number to which HHLA reports may be transmitted)

Name fax is going to: ____
(Please Print)

Client acknowledges to HHLA that Client is solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location, access and use of such facsimile machine and printers complies with all applicable HIPAA regulations. Client may revoke this authorization or change the facsimile number only by giving HHLA at least five (5) days prior written notice that must be delivered to HHLA. This revocation may be by facsimile transmission. **[Fax 615-771-0335]**

Client Name: ______________________________________
(Please Print)

Client Address: ______________________________________

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Signed By: ____

Printed Name: ______________________________________

Title/Position: ______________________________________

Phone Number: ______________________________________

PLEASE SIGN AND FAX A COPY OF THIS FORM TO: Home Healthcare Laboratory of America
[Atten: HIPAA OFFICER at HHLA- Fax 615-771-0335]