4605 Papermill Drive
Knoxville, TN 37909
865-584-3926
865-584-3645 (fax)

MOBILE DIAGNOSTICS INC.

601 Wall Street
Sevierville, TN 37862
865-429-5800
865-429-5840 (fax)

HIPAA Authorization and Release

A. I,_____, give Mobile Diagnostics, Inc. my consent to use or disclose my protected health information as described below. I hereby authorize Mobile Diagnostics, Inc. and any of its employees to use or disclose my Patient Health Information to the following person(s) or entity(s):

Release screening results to: _____

**If authorizer is a minor, please list parent or guardian in addition to employer.*

B. **Patient Health Information to be Disclosed for Employment Screening Purposes:**

Drug Screen Results	**_____ (initials)**	*Physical Results*	**_____ (initials)**
Breath Alcohol Results	**_____ (initials)**	*TB Test Results*	**_____ (initials)**
Other: _____	**_____ (initials)**		

C. **Purpose**: This disclosure is authorized at the request of the individual.

D. For the protected health information I have given permission to be disclosed, Mobile Diagnostics, Inc. can talk to, or give copies of said records to any of the person(s) or entity(s) I have permitted and can give this information by paper, fax, computer or electronic copies of those records. I, hereby, RELEASE and discharge Mobile Diagnostics, Inc. from any and all, known or unknown, liability, claim, or cause of action relating to the screening services provided by Mobile Diagnostics, Inc. and the communication of the results of those screening services. This release shall be binding on my heirs, legal representatives, and assigns. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected by federal privacy regulations for reasons beyond Mobile Diagnostics, Inc.'s control. **_____ (initials)**

E. **I understand I have the right to**:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect the office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Refuse to sign this authorization.
3. Restrict what is disclosed with this authorization.

F. **I understand**:

1. I may revoke this authorization in writing, except to the extent that Mobile Diagnostics, Inc. has taken action in reliance thereon.
2. I am requesting that Mobile Diagnostics, Inc. perform the employment screening services set forth above inasmuch as such services are a condition of my employment with my Employer. I understand that Mobile Diagnostics, Inc. may condition its provision of services to me upon its receipt of this signed authorization and release and that the results of such services are to be provided to my Employer.
3. There is the potential for the protected health information authorized to be disclosed by this authorization to be subject to redisclosure by the recipient and no longer be protected health information.
4. This authorization expires three (3) years from the date of this agreement.

G. **I have read and fully understand the above:**

_____	_____	_____
Signature of Employee/Applicant	Date Signed	Printed Name
_____	_____	_____
Signature of Parent/Guardian (if applicable)	Date Signed	Printed Name

*****Please contact your employer directly for screening results*****