



**LABORATORY SERVICES AGREEMENT
QUEST DIAGNOSTICS AND DOCTOR'S CHOICE**

EMPLOYER SOLUTIONS CLINICAL SECURE FAX FORM

Dear Ordering Clinician:

Pursuant to the terms of your arrangement with Doctor's Choice, you have directed Quest Diagnostics to release all laboratory test results to Doctor's Choice, which is acting on your behalf as your "Business Associate" as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Other than critical results, which will be transmitted to your office by facsimile, Doctor's Choice will receive all the results from all of the tests that you order. By executing this document, you authorize such a disclosure of test results to Doctor's Choice, and you represent and warrant that if required, you have obtained any appropriate consent forms or authorizations required by your patients for whom you have ordered laboratory testing. If you agree to the guidelines as explained in this communication, we will be able to begin transmitting once you have completed this form and returned it to us.

Because we are transferring confidential patient medical information to your office in the facsimile transmissions, we ask that you verify that your receiving fax machine is in a secure location. We also require you to verify your fax number. If your fax machine prints on paper that may fade over time, you should make a copy of the faxed report to ensure longevity of the test report. Please provide the information requested below and fax this form to Quest Diagnostics at the number listed at the bottom of this letter.

Return of this letter by you constitutes your representation that the facsimile machine identified below for receiving the electronic transmission of your patients' test results is in a non-public and confidential area. You agree to advise Quest Diagnostics prior to changing your facsimile number. As the Client, you are solely responsible for transmissions of your patients' test results to fax numbers that were changed without prior notice to Quest Diagnostics. The signer of this document represents that he/she has the authority to sign this document on behalf of the Client, and acknowledges that Client is responsible for maintaining the security and confidentiality of the reports sent to the Telephone Number listed below.

Fax Format-Fax number entered in our database for faxing of critical reports.

Please complete information below. Account number(s) will be assigned by Quest Diagnostics Employer Solutions once the paperwork has been returned.

Account Name: _____

Address where Fax is located: _____

Secure Fax Phone Number: _____

Effective Date: _____

Authorized Contact: _____ Contact Phone #: _____

Physician (Authorized) Signature: _____ Date: _____

Please PRINT Physicians' Name: _____ License #: _____

Account Number(s): _____

Please fax this letter back to FAX #: 888-952-2723

