PATIENT REGISTRATION FORM

Acknowledgement of Receipt of Privacy Notice

Patient Information			
Name (First MI, Last)		SSN	Date
Address	City	State	Zip
Date of Birth	Gender ☐Male ☐Female	Home Phone	Cell Phone
Patient Employer/School			Work Phone
Emergency Contact		Relationship	Phone
Email:			

I have received a copy of the Express Lab Notice of Privacy Practices. In connection with the medical services that I am receiving from Express Lab, I hereby authorize the practice to disclose any or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to the following:

- Any third-party payer covering the medical services of the patient.
- Other health care professionals and institutions involved in the delivery of health care to the patient.
- The proponent of any legally sufficient subpoena, or in response to a court order.
- Employees and agents of the practice, to the degree necessary to facilitate the provision of health-care services and payments for such services.
- Pharmacies
- Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.
Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

This consent is valid from the date executed until revoked in writing by myself.
Signed:__________________________________ Date:_______________________

If not signed by the patient, please indicate relationship to the patient (e.g., spouse)
Relationship:______________________________

Medicare Lifetime Signature Authorization (Medicare Patients Only)

I request that payment of authorized Medicare benefits be made to either me or on my behalf for any services furnished me by Express Lab. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.
Signed:____________________________________ Date:________________________

Express Lab LLC
3910 Washington Parkway Ste. B
Idaho Falls, ID 83404