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## FACSIMILE LABORATORY REPORTING AGREEMENT/UNDERSTANDING Health Insurance Portability and Accountability Act (HIPAA) Compliance

As an Anatomic Pathology Services provider to "YOU" our valued client, we are committed to providing full compliance with the regulations promulgated pursuant to the Healthcare Information Portability and Accountability Act of 1996 (HIPAA). Clinical laboratory reports contain information that is deemed Protected Health Information and, as such, Advanced Clinical Laboratories (ACL) endeavors to provide compliant transmission of Protected Health Information data in a variety of modes, such as encrypted data transmissions to computers via our AP Easy™ (ACL Software), and IP remote printer systems. Although the use of unencrypted facsimile (FAX) transmission of Protected Health Information via standard telephone lines is not specifically prohibited by current HIPAA regulations, these **data must be transmitted to a FAX machine that is physically located in a secured location with access limited to the staff of the Hospital, Office, or Clinic being served by L.A. Good Samaritan Pathology Medical Group, Inc. dba Advanced Clinical Laboratories (ACL).**

ACL Client number: \_\_\_\_\_

Client Name: \_\_\_\_\_

Client Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

In order to provide our clients with access to PHI data via FAX, ACL requires that clients supply us with the access phone number of a physically secured facsimile machine and certification that access to that machine is restricted to Hospitals, physicians, Clinics and staff members to prevent the unauthorized release of PHI.

Secure FAX Number (\_\_\_\_): \_\_\_\_\_ - \_\_\_\_\_

Voice Phone Number (\_\_\_\_): \_\_\_\_\_ - \_\_\_\_\_

As the above named client or manager of the office cited above, I hereby request and authorize that Advanced Clinical Laboratories transmit via telephonic facsimile, laboratory reports to a facsimile machine that is securely maintained in our office that is accessed by the Secure Fax Number cited above.

LAB USE ONLY	
Auto Fax? Yes [ ] No [ ]	
Received ____ / ____ / 20	
Entered: ____ / ____ / 20	
By C/S Rep: _____	
ORIGINAL TO CLIENT FILE	

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please kindly fax back to (562) 981-0600 upon completion of this form.**