HIPAA CONSENT FORM

PHYSICIAN INFORMATION

Name | Date

National Provider ID

Email | Phone Number

ACCOUNT INFORMATION

Practice/Hospital

Address

City | State | Zip

Phone Number | Fax Number

APPROVED PERSON(S) TO HAVE ACCESS TO RESULTS REPORT AND WEB-PORTAL

Name	Rep Group	Phone Number	Email

REPORT: HIPAA COMPLIANT OHANA LABORATORIES LIM SYSTEM WEB PORTAL

Clinician Acknowledgement: *By signing below, I authorize Ohana Labs to provide access to the person(s) named above to view and access patient RESULTS and REPORTS.*

Clinician Name (*print*)

Signature | Date

Ohana Laboratories, Inc. ▪ CLIA No. 12D2018115
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