# 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 |
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## REPORT: HIPAA COMPLIANT NEXTGEN LABORATORIES LIM SYSTEM WEB PORTAL

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

Clinician Name (*print*)

Signature | Date

**NextGen Laboratories, Inc.** ▪ CLIA No. 05D0907431
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