San Diego County Public Health Laboratory
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LIVE WELL SAN DIEGO

CLIENT AGREEMENT FORM

This agreement should be completed in full by parties who are receiving personal health information to ensure test results are sent in a secure environment. The recipient agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA) provision. Additionally, the recipient will protect the confidentiality of emailed or faxed test results, use a fax machine in a secured area, and comply with the confidentiality notice below. If the recipient is in agreement, please provide the information below on an annual basis or if any changes occur to ensure accurate up-to-date communication and method of delivery.

Confidentiality notice: The documents accompanying this transmission may contain confidential health information that is privileged, confidential and exempt from disclosure under law. This information is intended only for the use of the entity or individual named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Facility Information	
Facility Name:	Phone Number:
Address (Street, City, State, Zip):	
Secure Delivery Information	
Method of Delivery: ☐ Email Address ☐ Fax Machine or System	
Email (preferred) or Fax:	
Fax location address if different than above:	
Contact Information	
Name:	Title:
Phone Number:	Email:
Authorized Official Information	
Name:	Title:
Phone Number:	Email:
The undersigned certifies that the forgoing information is correct and agrees to abide by all terms and conditions contained in this agreement.	
Authorized Official Signature:	Date:
Once completed, email to Labs.HHSA@sdcounty.ca.gov or fax to (858) 268-4102.	

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LIMS Section		
Entry Date:	Client ID:	Expiration Date: