CLIENT/HEALTH CARE PROVIDER AGREEMENT
AUTOFAXING OF LAB AND DIAGNOSTIC IMAGING REPORTS

Please attach to Assyst Service Request or FAX the completed form to the LIS Coordinator/LAB Manager/ Designate at the number below.

Initial the appropriate action box

START - AUTOFAX The undersigned agrees to:

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- participate in a program that will FAX laboratory and diagnostic imaging reports (when available) to his or her facility's FAX machine.
- ensure the security of the confidential information being transmitted by FAX by placing the receiving FAX unit in a secure location, accessible **ONLY** to the undersigned or appropriate designated persons and to inform the laboratory or DI department of any planned changes to fax numbers or client/physician information.

NOTE:

- ***Laboratory Services, Diagnostic Imaging department or NSHA-IM/IT*** *is unable to phone the receiving client either immediately prior to transmission or immediately after transmission for confirmation of receipt of information.*
- *If the FAX fails after several attempts, the reports will print to the site's designated printer. The site's department will distribute these reports to the appropriate Health Care Provider.*
- *A plain paper FAX machine is required.*
- *Diagnostic Imaging reports will fax immediately upon reaching a signed status. Lab reports will print at designated print times.*

CHANGE - AUTOFAX NUMBER The undersigned requests:

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- a change to the fax number presently in use for autofaxing.

Previous Fax#:_____ **New Fax#:** _____

STOP - AUTOFAX The undersigned agrees to:

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- Stop participation in the above program which will end the faxing of laboratory and diagnostic imaging reports to his or her facility's FAX machine. Reports will now be printed to the site's designated printer in the relevant department (Lab or Diagnostic Imaging).

Completion of this section confirms your agreement to assume responsibility for the appropriate actions listed above:

Client/Health Care Provider (print): _____ PMB #: _____

Date of Request: _____ Office Phone #: _____ **Office Fax #**: _____

Address: _____

Signature of Client/Health Care Provider: _____

Did you confirm a test fax to the Office Fax # above? ☐ **Yes** ☐ **No**

Contact Person (print): _____ Phone Number: _____

Fax Number to return to LAB: _____

Signature of LIS Coordinator/Facility Manager/Lab Contact: _____

Revised JUNE 2021

IM/IT recommends that the Site LAB keep a copy of the completed form on file.
Allow UP TO 14 days to implement the appropriate changes.