



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

## CHAIN OF TRUST AGREEMENT

The undersigned Client hereby authorizes Interpath Laboratory, Inc. to deliver Protected Healthcare Information as that term is defined by the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160-64 (HIPAA). Client acknowledges sole responsibility for HIPAA compliance related to the Protected Healthcare Information delivered by Interpath, following "Point of Transfer" of such material from Interpath to Client.

- Printer                      Description: \_\_\_\_\_
- Fax Machine                Fax Number: \_\_\_\_\_
- Courier Delivery          Point of Transfer: \_\_\_\_\_
- Electronic Delivery      Client system receipt of Electronic Protected Health Information

Client may revoke this authorization or change the facsimile number only by giving Interpath Laboratory at least five (5) days prior written notice which notice must be faxed to Interpath Laboratory at facsimile number (541) 278-4761 and also must be mailed to Interpath Laboratory at the following address: P.O. Box 1208, Pendleton, OR 97801.

Client Number: \_\_\_\_\_

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

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

\_\_\_\_\_

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title/Position: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**PLEASE SIGN AND FAX A COPY OF THIS FORM TO:**  
Interpath Laboratory, Inc. Facsimile No. (541) 278-4761