

**ATTACHMENT F/ HEALTH CARE PROVIDER  
CLINICAL MESSAGING  
QUEST DIAGNOSTICS PROVIDER AUTHORIZATION**

By signing this document, the WVHIN Participating Organization listed below authorizes the release of its lab results ordered from Quest Diagnostics into the WVHIN Health Information Exchange. All WVHIN Policies and Procedures apply to this data transfer. Either Party may terminate this agreement at any time upon 15 days' written notice. Please complete the requested information below and return to the WVHIN.

Participating Organization: \_\_\_\_\_  
(Legal Name)

Quest Account Number: \_\_\_\_\_

*\*\*\*Additional Quest account numbers, complete additional forms or include a separate list with address associated with each number.\*\*\**

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_

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

Title: \_\_\_\_\_

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

**Return completed form to:**

WVHIN  
101 Washington Street East, Ste 124    OR    [info@wvhin.org](mailto:info@wvhin.org)    OR    Fax: 681.265.3898  
Charleston, WV 25301

Questions should be directed to the WVHIN at 304.558.4503 or [info@wvhin.org](mailto:info@wvhin.org); or  
your Quest Diagnostics Account Representative