Ambry Genetics®
A Konica Minolta Company

HIPAA Authorization/Disclosure of Protected Health Information

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth

Address

Email Address	Phone Number

RECIPIENT (if patient is requesting information/materials, note: self)

Last Name	First Name	Middle Initial	Title

Facility Name and Address

Phone Number	Fax Number	Email Address

WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?*

Date(s)/Name(s) of Testing: _____

☐ Laboratory Results

☐ Itemized Billing Statement

☐ Other: _____

**California Patients: If this authorization is for mental health/substance abuse or HIV information, a separate completed authorization form from those above will be necessary for release of (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released.*

DELIVERY METHOD (SELECT ONE) TO ADDRESS LISTED BELOW

☐ Pick Up (a government issued ID will be required)
☐ U.S. Mail
☐ Fax
☐ Email (encryption will be used and you will need to create a password)

Send to:

_____
_____
_____
_____

IDENTIFYING INFORMATION ATTACHED (AMBRY RESERVES THE RIGHT TO VERIFY THE IDENTITY OF ANY REQUESTOR OF PHI)

☐ Driver's License
☐ DMV Identification Card
☐ State Or Federal Employee Id Card
☐ Passport

☐ If personal representative of a deceased patient, please provide one of the following (or similar):**
- ☐ Copy of Power of Attorney
- ☐ Advanced Directive
- ☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependent healthcare coverage)

***Beneficiary or personal representative of deceased patient: It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*

☐ For a deceased patient:
- ☐ A copy of the death certificate identifying the surviving spouse is acceptable and allows the surviving spouse to sign this authorization.
- ☐ Other deceased patients: a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of estate.

PATIENT/PERSONAL REPRESENTATIVE AUTHORIZATION & APPROVAL

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature (otherwise considered the Effective date of the authorization). If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care)
☐ Guardian or conservator of an incompetent patient

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PATIENT/REPRESENTATIVE RIGHTS

- I understand I have the right to request a copy of my Laboratory report/records and that Ambry is required to provide them within thirty (30) calendar days of receipt of this completed request. If this request is denied or Ambry cannot respond within 30 calendar days, Ambry will notify me in writing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that my testing, treatment, payment, enrollment, or eligibility for benefits of clinical laboratory testing services will not be conditioned on or affected by whether I sign this authorization.
- I understand that this medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.
- I understand that once Ambry discloses my health information by my request, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.
- I understand that I have the right to receive a copy of this authorization.
- I understand that if I have any questions about this authorization, I may contact Ambry Genetics at 866-262- 7943, for more information about this authorization, or about privacy issues.

REQUESTOR SIGNATURE

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT AND UNDERSTAND THAT ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

Name of Signatory: _____

Signed/Date: _____

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