Ambry Genetics®

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

☐ U.S. Mail
☐ Fax
☐ Email (encryption will be used and you will need to create a password)
☐ Unencrypted copy by email to patient (Note: you assume the risk of unauthorized access or disclosure of your health information)

Send to:

_____
_____
_____
_____

IDENTIFYING INFORMATION ATTACHED
(AMBRY GENETICS 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
☐ For a deceased patient, please provide the following in addition to the identifying information above:
  ☐ A copy of the death certificate or other document indicating patient is deceased.
  ☐ If requestor is not a family member a document showing requestor has the right to receive the information (e.g. power of attorney, court order, appointment as executor, or administrator of the estate).

PATIENT AUTHORIZATION

I hereby authorize the disclosure of my health information to the following individuals listed below. This authorization is valid for 12 months from the date of signature (otherwise considered the Effective date of the authorization).

1. _____

2. _____

3. _____

Ambry Genetics®

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.

If not signed by patient, please indicate your relationship to the patient below:

☐ Parent or guardian of minor patient (to the extent minor could not have consent to care)
☐ Guardian or conservator of an incompetent patient
☐ Patient's medical provider (attesting to have the appropriate consent from above-named patient)

Name of Signatory: _____

Signed/Date: _____

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