MYPG

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PURPOSE

To authorize Personal Genome Diagnostics (PGDx) to request/obtain patient's tumor sample(s) for clinical testing purposes and/or medical records for payment of insurance claim

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI

DATE OF BIRTH | STREET ADDRESS

CITY

STATE | ZIP CODE

PHONE

ORDERING PHYSICIAN INFORMATION

ORDERING PHYSICIAN

STREET ADDRESS

CITY

STATE | ZIP CODE

PHONE

PATIENT AUTHORIZATION

I hereby authorize (doctor's name)_____
to release the following information to Personal Genome Diagnostics, 2809 Boston Street, Suite 503, Baltimore, MD 21224, (443) 602-8833.

INFORMATION TO BE RELEASED

- Clinical Notes
- Pathology Reports
- Laboratory Reports
- Pathology Samples/Slides

I UNDERSTAND THAT

- This authorization is voluntary.
- If I do not sign this authorization, PGDx will not disclose my health information as requested.
- This authorization is valid for one (1) year from the date of signing unless I indicate an earlier date here: _____.
- Once my health information is disclosed as requested, it may no longer be protected by federal/state laws and could be re-disclosed by the person(s) receiving it.

ATTENTION: PLEASE READ CAREFULLY. By signing, you agree that you understand and accept these terms:

- **IF THE PATIENT IS 18 YEARS OF AGE OR OLDER**, the patient must sign and date the form.
- **IF THE PATIENT IS 18 YEARS OF AGE OR OLDER AND IS INCAPABLE OF SIGNING**, a legally authorized substitute may sign and date the form.
  Please indicate your legal authority and include documentation of your relationship.
  ◯ Legal Guardian/Conservator ◯ Health Care Agent/Power of Attorney
- **IF THE PATIENT IS 17 YEARS OF AGE OR YOUNGER,** the patient's parent or legal guardian must sign and date the form.
  Please indicate your relationship.
  ◯ Parent ◯ Legal Guardian

SIGNATURE

PRINTED NAME OF PATIENT	PATIENT'S SIGNATURE	DATE SIGNED
OR PRINTED NAME OF REPRESENTATIVE	REPRESENTATIVE'S SIGNATURE	DATE SIGNED