Ambry Genetics

HIPAA AUTHORIZATON / ROI for Use/Disclosure
Request for Protected Health Information

Patient Information				Clinician/Entity to Disclose Information/Materials To (RECIPIENT)			
Last Name	First Name	Middle Initial	Date of Birth	Last Name	First Name	Middle Initial	
				Title			
Address				Facility Name and Address			
Telephone #	Email Address			Telephone #	Fax #	Email Address	

MATERIAL RECEIPT/CUSTODIAN Acknowledgement-ONLY IF MATERIALS ARE TRANSFERRED

In the event that materials are received (DNA tubes, tissue blocks or slides, Original sample, etc.) as listed in the section below, I hereby acknowledge that I am retaining full custodian responsibilities of said materials and acknowledge that Ambry Genetics is no longer in possession of stated materials. Any further requests for the listed materials will be forwarded to me or my facility for response.

☐ DNA Tube ID: Sample ID: _____

o Number of Tubes/Containers: _____

o All materials relinquished (i.e. Ambry Genetics retains no further material)? ☐ YES ☐ NO

Name of RECIPIENT Signatory: _____ ** Signed:* _____ *Dated:* _____

Patient/Representative Disclaimer

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this Clinical Laboratory may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I understand that I may revoke this authorization at any time notifying this Clinical Laboratory in writing. My revocation will not affect actions taken by this Clinical Laboratory prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

If I have any questions about this authorization, I may contact client services or Ambry Genetics Privacy Officer at Ambry Genetics at 866-262-7943, who will provide me with more information about this authorization, or about privacy issues. I may be provided a copy of the completed Authorization to Release Information form upon request.

Clinical Laboratory

** For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. 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.*

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

Patient / Personal Representative Authorization & Approval

I hereby authorize this Clinical Laboratory to use and disclose health information or requested materials concerning the above listed Patient to the stated RECIPIENT.

Health information/materials to be used or disclosed: *

PLEASE CHECK ONE AND NOTE EXCEPTIONS:

☐ Sample related materials (ex. DNA, tissue, slides)

☐ Any and all health information or materials may be released, including, but not limited to, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____

The information/materials may be used only for the following purposes:

At the request of the individual or their personal representative

Effect of Refusal to Sign Authorization

I understand that my clinical laboratory testing services or benefits will not be affected whether I sign or do not sign this form. This authorization is effective now and will remain in effect until:

_____

(Expiration event or date; can be indefinite)

I understand that I have the right to receive a copy of this 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*

☐ *Beneficiary or personal representative of deceased patient ***

- *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)*

NOTE : PLEASE PROVIDE A COPY OF SIGNATORS DRIVERS LICENSE FOR VERIFICATION PURPOSES:

Name of Signatory: _____

** Signed:* _____ *Dated:* _____

PLEASE FAX THIS FORM TO AMBRY GENETICS UPON COMPLETION at 949-900-5501

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