**Authorization For Use And/Or Disclosure of Protected Health Information**

Use this form to authorize GENETWORx to disclose your protected health information to a specific person or entity. If you are completing this form yourself, please fill out Sections A through E. If you are filling out this form on the behalf of someone else, please complete Sections A through D and Section F.

**Section A: Individual** – Complete the name and information of the person whose protected health information is being disclosed.

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | Daytime Phone | |
| Address | | | Date of Birth |
| City | State | | Zip |

**Section B: Description of protected health information to be disclosed** – Describe in detail the protected health information to be used and disclosed (you can state “any and all” or provide specific information such as the specific laboratory tests completed that you would like to disclose):

|  |
| --- |
|  |

Please check if your authorization will include the disclosure of the following types of *sensitive* protected health information:

|  |  |
| --- | --- |
|  | **Sexually transmitted or “communicable” diseases (includes COVID-19)** |
|  | **Genetic Testing** |

**Section C: Authorized recipient of the protected health information** – State who you are authorizing to receive protected health information. *If protected health information is disclosed under your authorization to persons or organization that are not subject to federal or state privacy laws, it may by re-disclosed and no longer protected.*

I authorize you to disclose my protected health information to the following person(s) and entities:

|  |
| --- |
|  |

The purpose(s) of this disclosure is (you may state “at my request”):

|  |
| --- |
|  |

**Section D: Expiration and revocation**

This authorization will expire on: (must choose one)

|  |  |  |  |
| --- | --- | --- | --- |
|  | 1 year from the date it is signed |  | Other (insert date or event): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I understand that I can revoke this authorization at any time by calling 855-436-8979. I understand that revocation will not affect actions taken prior to our receipt of any revocation request.

**Section E: Signature**

I understand that this authorization is voluntary.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Signature Date*

**This form must also be signed by a witness**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Witness Signature Date*

|  |  |
| --- | --- |
|  | Please deliver the results by email. I understand that email is not a secure way to transmit private health information and I take full responsibility for any breach of Privacy in the transmission of these results.  EMAIL Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section F: Personal representative** – If you are not the patient, please sign and date Section F of this form. Check the box that describes your relationship to the individual. **If you are not the parent, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc).**

Printed name of personal representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of personal representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Parent of minor child |  | Legal guardian |  | Power of attorney |  | Executor |  | Other |

**This form must also be signed by a witness**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Witness Signature Date*

|  |
| --- |
| **\*You must include proof of identity with this completed form. Please attach a copy of your Driver’s License, Passport, or similar picture identification to this form.**  **Mail or fax your completed signed authorization and documentation to:**  **GENETWORx**  **4060 Innslake Drive**  **Glen Allen, VA 23060**  **Fax: 866-704-3113**  **Phone: 855-436-8979** |