Authorization of One-Time Release of Personal Health Information

INFORM DIAGNOSTICS
A FULGENT GENETICS COMPANY

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Previous Last Name (if applicable) _____ Date of Birth _____ (MM/DD/YYYY)

Street Address _____ Phone _____

City _____ State _____ Zip _____

To verify your identity and comply with federal privacy regulations, please include a copy of a government-issued photo ID with your request.
Acceptable forms of ID include: Driver's License, U.S. Passport, or State-Issued ID Card.

NAME OF REQUESTOR (if different from patient)

Name of Requestor _____

Relationship to Patient ☐ Self ☐ Parent ☐ Legal Guardian (attach legal documentation)

☐ Other (specify and attach legal documentation) _____

REQUESTED INFORMATION

I hereby authorize Inform Diagnostics to release the following information for the above named patient:

☐ Statement cost
from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

☐ Medical records
from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

☐ Other health information (please specify) _____
from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

RELEASE TO

This information should be sent to ☐ Same as patient address above ☐ Different address below

Name/Attn _____

Organization/Entity _____

Street Address _____

City _____ State _____ Zip _____

PURPOSE

The purpose of this Authorization is

☐ At request of patient ☐ Required or requested by recipient for purpose of _____

☐ Other _____

EXPIRATION & AGREEMENT

Authorization will expire 90 days from the date this Authorization is executed.
I understand that I have a right to revoke this Authorization at any time. This revocation will not affect any uses and/or disclosures already made based on this Authorization before the revocation is received by Inform Diagnostics. The revocation must be in writing and mailed to the address below. I understand that Inform Diagnostics may not condition any treatment, payment, enrollment or my eligibility for benefits on my signing this Authorization. I understand that the information used and/or disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law.

I certify that the foregoing information is true and correct.

Signature _____ Date _____

Printed Name _____

If signed by someone other than the above named patient, please describe your legal authority to act on behalf of the patient and, if applicable, attach supporting documentation.

Witness Signature _____ Date _____

Witness Printed Name _____

1111 S. Freeport Pkwy., Coppell, TX 75019 Fax to: 866.688.3280