Authorization for Release of Protected Health Information

Form Instructions: All sections of this form **MUST** be completed.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This information may be redisclosed if the recipient(s) identified in section 8 is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.
2. I have a right to refuse to sign this authorization and my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form.
3. I have a right to receive a copy of this form after I have signed it.
4. If I sign this authorization, I have the right to revoke it at any time, except to the extent that the organization has already taken action based upon my authorization. To revoke this authorization, I must write to the OmniSeq Privacy Officer, 700 Ellicott St., Buffalo, New York 14203.

5. **Patient information:**

   Name: _____ Phone Number: (____) _____

   Address: _____ Date of Birth: _____

   _____

6. **Who will disclose the information?** OmniSeq, LLC

7. **Who will receive the information?** Provide the name and address of person(s) or category of person to whom this information will be sent. If an email address is provided, the information will be sent via encrypted email.

   1. Name: _____
      Address: _____
      _____
      Email: _____
      Relationship (if applicable): _____

   2. Name: _____
      Address: _____
      _____
      Email: _____
      Relationship (if applicable): _____

8. **What information will be disclosed?** Specify the information that is to be released.

   ☐ Completed laboratory test reports from tests on (insert approximate date(s) of tests):

   _____ _____ _____ _____

9. **What is the reason for the disclosure?** Indicate the reason for the release of information.

   ☐ At the request of the individual

   ☐ Other (specify): _____

10. **When will this authorization expire?** Identify the date or event on which this authorization will expire.

    _____

SIGNATURE: I have read this form and all of my questions about this form have been answered.

_____ _____

Signature of Patient or Personal Representative Authorized by Law Date

_____

Description of Personal Representative's Authority