# Authorization for Release of Health Information to Clinical Laboratory

**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.

1. **Patient information:**

| | |
|---|---|
| Name: | Date of Birth: |
| Address: | Phone number: (  )- |
| City/State: | Zip Code: |

2. Facility Holding Specimen Authorized by Patient for Release of Specimen:

| Hospital/Lab Name: | Address: |
|---|---|
| | |

3. Release of Health Information Authorized to be Made to:

| | |
|---|---|
| OmniSeq, Inc.<br>Attention: Lab Specimen Receiving<br>700 Ellicott Street, 3rd Floor<br>Buffalo, NY 14203 | Phone: 1-800-781-1259<br>Fax: 1- 888-770-4931 |

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

| Requested Material/Information | Procedure Date, if known, or approximate: |
|---|---|
| ☒ Block | |
| ☒ Slides | |
| ☐ Blood | |
| ☐ Bone Marrow | |
| ☐ Other (Specify: ) | |
| ☒ Completed pathology/lab report from same date(s) | |

5. **What is the reason for the disclosure?** Molecular diagnostic testing ordered by _____, M.D.

I understand that:

6. Signing this Authorization is voluntary and my refusal to sign this authorization will not affect my treatment, payment, enrollment in a health plan or eligibility for benefits.
7. I have a right to receive a copy of this form after I have signed it.
8. 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.

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**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