



OmniSeq Specimen Authorization Form

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. Attention: Lab Specimen Receiving 700 Ellicott Street, 3 rd Floor Buffalo, NY 14203	Phone: 1-800-781-1259 Fax: 1- 888-770-4931
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4. What information will be disclosed? Specify the specimen information that is to be released.

Requested Material/Information	Procedure Date, if known, or approximate:
<input checked="" type="checkbox"/> Block	
<input checked="" type="checkbox"/> Slides	
<input type="checkbox"/> Blood	
<input type="checkbox"/> Bone Marrow	
<input type="checkbox"/> Other (Specify:)	
<input checked="" type="checkbox"/> 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.

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	