AUTHORIZATION FOR RELEASE OF PATIENT TEST RESULTS AND/OR GENETIC COUNSELING REPORT

GeneDx

Return to GeneDx by fax: (201) 421-2010 Or email: support@genedx.com

Please submit requests after testing is complete to avoid delays. Your request will be processed within 30 days (for GeneDx testing) or 60 days (for Sema4 testing) of our receipt of this completed form.

Service performed by: ○ GeneDx ○ Sema4 ○ Unknown

PATIENT INFORMATION: (*Indicates required field)			
First*	Middle	Last*	DOB*
Street	City	State	Zip
Phone*: _____ ○ Home ○ Cell ○ Business			
Ordering Provider		Date of Service	Lab ID(s)

RELEASE RECORDS TO: (*Indicates required field)			
Recipient 1: Records to be released (check all that apply)*: ○ Test report(s) ○ Genetic Counseling Report(s)			
Preferred Method of Delivery (choose one)*: ○ Fax ○ Secure Email ○ Mail			
Name*		Email	
Street	City	State	ZIP
Phone*		Fax Number	
Recipient 2: Records to be released (check all that apply)*: ○ Test report(s) ○ Genetic Counseling Report(s)			
Preferred Method of Delivery (choose one)*: ○ Fax ○ Secure Email ○ Mail			
Name*		Email	
Street	City	State	ZIP
Phone*		Fax Number	

MEDICAL RECORDS RELEASE CONSENT (REQUIRED)

By my signature below, I authorize GeneDx, LLC, to discuss and to release the patient records described above to the address, fax number, or email address provided, and I represent that I am authorized to make this request.

I understand that the information disclosed by this authorization may be redisclosed by the recipient, and may no longer be protected by federal privacy regulations.

I understand that GeneDx will not condition any treatment or care on my providing this authorization.

I understand that this authorization is valid for one year from this date (or until _____) and I may revoke this authorization by notifying GeneDx, LLC at privacy@genedx.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

My purpose/use of the information is for_____

Authorized Signature	**Date**	**If other than patient, print full name**

Relationship to patient: ○ Self ○ Parent ○ Guardian ○ Other (Specify)_____

○ Power of attorney or other evidence of the person's authority to act as a personal representative of the patient is attached.

ADDITIONAL INFORMATION RELEASE CONSENT

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I am a resident of New York and experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights. UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

○ YES, DISCLOSE THIS INFORMATION * ○ NO, DO NOT DISCLOSE THIS INFORMATION *

Authorized Signature of Patient