AUTHORIZATION FOR RELEASE OF PATIENT TEST RESULTS AND/OR EXOME SEQUENCING DATA

Return Fax: _____ Attention: _____

Your request will be processed within 30 days of our receipt of this completed form.

PATIENT INFORMATION: (*Indicates required field) A separate form must be completed for each patient or family member requesting the release of results and/exome data.

First*	Middle*	Last*	DOB*
Street	City	State	ZIP
Home Phone*	Cell Phone*	Business Phone*	

Ordering Physician: _____ Date of Collection: _____

Lab ID(s): _____ _____ _____ _____

RELEASE TEST RESULTS TO: (*Indicates required field)

☐ Self ☐ Attorney ☐ Insurance Company or Designee ☐ Healthcare Provider ☐ Employer

☐ Other: _____

Preferred Method of Delivery: ☐ Fax ☐ Mail ☐ Secure Email ☐ Un-secure Email

Name*			
Street	City	State	ZIP
Phone*	Fax Number		
Email			

RELEASE OF EXOME SEQUENCING DATA FROM XOMEDX TESTING TO:

☐ Self ☐ Healthcare Provider ☐ Researcher* ☐ Other: _____

*If data is being released for research purposes, a separate Research Consent must be signed and submitted.

Preferred Format of Data: ☐ CRAM and VCF ☐ VCF only

A secure link to download the requested exome sequencing data will be emailed to the address listed below.

Name*			
Street*	City*	State*	ZIP*
Business Phone*	Fax Number		
Email*			

Consent

I ☐ do ☐ do not give GeneDx permission to share and discuss my genetic test results with the above named person, if different from patient. (please select one)

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying the Privacy Officer of BioReference Laboratories, Inc., 481 Edward H. Ross Drive, Elmwood Park, NJ 07407 or Privacy@bioreference.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 _____

This authorization expires on _____ , 20 ___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____ .

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* _____

By my signature below, I authorize BioReference Laboratories, Inc. to release the above individual's test results to the above address, fax number, or email address provided, or to release the above individual's exome sequence data to the above address and that I am authorized to make this request.

Authorized Signature: _____ Date: _____

If other than patient, print full name: _____ Relationship to patient: ☐ 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.

☐ Please check this box to be enrolled in our patient portal to receive a notification email regarding results that are ready to be viewed. ****Results cannot be released until 5 days after a report is final****

PLEASE RETURN THIS FORM TO GENEDX BY FAX, MAIL OR EMAIL:
PATIENT RECORDS RELEASE: 207 PERRY PARKWAY GAITHERSBURG, MD 20877 • FAX: 301-519-2892 • EMAIL: zebras@genedx.com
CALL US AT 301-519-2100 WITH QUESTIONS.