Authorization for Release of Information **Fax 617-401-4032**

Full Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip code: _____

I hereby authorize StrataDx. to release my information to: _____

_____

Information to be released: ☐ Lab report(s) ☐ Slide(s) ☐ Block(s)

☐ Other: _____

Dates: _____ ☐ All dates included

Purpose of Disclosure:

☐ Changing Physicians ☐ Consultation ☐ Continuing Care ☐ Legal
☐ Workers' Compensation ☐ School ☐ Insurance ☐ Other_____

I understand that this authorization may only be used for the disclosure listed above, and that the authorization will expire 30 days after I have signed it. I understand that it will become a part of my medical record.

I understand that I may revoke this authorization at any time by notifying StrataDx in writing, and that it will be effective on the date notified except to the extent that action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

I understand that if I choose not to authorize the release of information, my healthcare and payment for my healthcare will not be affected.

I understand that I may see and obtain a copy of the records described in this authorization upon my request. Additionally, I may receive a copy of this authorization upon request.

I understand that I must present photo identification at the time of pick-up or upon FedEx delivery.

I understand that if I am not the patient, I must provide proof I am authorized to view/obtain that patient's medical information.

_____ _____
Patient/Representative Signature Date

_____ _____
Records Disclosed by (StrataDx Representative) Date

Accession number(s) released: _____

☐ Photo Identification Provided ☐ FedEx Direct Signature Required