

AUTHORIZATION FOR USE OR DISCLOSURE/RELEASE OF GENETIC INFORMATION

Patient Name (LAST, FIRST): _____

Birthdate (mm/dd/yy): ____/____/____ Lab Accession #: _____

I hereby authorize the Medical Genetics Laboratories, Department of Molecular and Human Genetics at Baylor College of Medicine to use or disclose/release my/my child's individually identifiable information as described below. I understand that if the organization authorized to receive the information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations:

Check all that apply:

- Laboratory report (specify test performed: _____)
- Extracted DNA sample
- Other sample (specify: _____)
- Other information (specify: _____)

Purpose for the Release:

- Additional Testing
- To interpret results for family member. Specify name(s): _____
- Other: _____

Information/sample to be released to:

Hospital /Physician/Laboratory Name: _____

Address: _____

Phone #: (____) _____ FAX #:(____) _____

In the case of a sample being sent to another diagnostic laboratory, please specify shipping conditions and the mode of shipment and the account number to be used for shipping (FEDEX, Airborne, etc):

Preferred Courier: _____ Account #: _____

Shipping Conditions: _____

I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or conditions:

Signed: _____

(Patient)

(date)

(or)

(Legal Representative)

(Relationship to patient)

(date)