CYREX® Laboratories

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Government issued photo ID must accompany this form and fees may apply to this request for records.

I, _____ authorize Cyrex Laboratories to use and/or disclose my protected health information (which may pertain to my diagnosis and treatment, laboratory test results, medical history billing information, ordering and/or treating physicians, and/or other related information) as specifically identified below and in the original request attached to this authorization and to the person(s) named in that request. I authorize attorney(s) and their legal staff, as well as the appropriate Cyrex employees, to use and/or disclose my PHI in accordance with this authorization. This use and/or disclosure of my PHI is at my own request. I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the person or party receiving it; in that case, the information may no longer be protected under federal and state health information privacy laws.

PATIENT:

First Name: **Middle Initial:** **Last Name:**

Date of Birth: mm/dd/yyyy / / **Gender:** ☐ Male ☐ Female **Phone:** ( )

Address: **Apt/Box:**

City: **State:** **Zip:**

ORDERING PHYSICIAN:

Physician Name (or practice name): **Phone:** ( )

Address: **City:** **State:** **Zip:**

Specific description of the protected health information that I authorize for disclosure: _____

_____

I understand that I may revoke this authorization in writing at any time [by sending a signed and dated written statement to Cyrex Laboratories saying that I am revoking my authorization to disclose health records,] except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

This authorization expires on _____ (date) , or in the event that _____ (event)

_____ , whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ _____

Signature Date

_____ _____

Name Relationship or Authority of Personal Representative (if applicable)