fulgent Oncology

Authorization of One-Time Release of Personal Health Information Form

Patient Information

LAST NAME | FIRST NAME | MIDDLE INITIAL

PREVIOUS LAST NAME (if applicable) | DATE OF BIRTH (MM/DD/YYYY)

STREET ADDRESS | PHONE

CITY | STATE | ZIP

Name of Requestor (if different from patient)

NAME OF REQUESTOR

RELATIONSHIP TO PATIENT ☐ Self ☐ Parent ☐ Legal Guardian (attach legal documentation)

☐ Other (specify and attach legal documentation) ____________________

Requested Information

I hereby authorize Fulgent Oncology to release the following information for the above named patient:

☐ Statement Cost From ____________ to ____________ (MM/DD/YYYY) (MM/DD/YYYY)

☐ Medical Records From ____________ to ____________ (MM/DD/YYYY) (MM/DD/YYYY)

☐ Other health information (please specify) ____________________ From ____________ to ____________ (MM/DD/YYYY) (MM/DD/YYYY)

Delivery Method

This information will be sent to ☐ Patient ☐ Facility ☐ Other ____________

NAME/ATTN

ORGANIZATION/ENTITY (Optional)

☐ Email ____________________ ☐ Fax ____________________

Purpose

The purpose of this Authorization is

☐ At request of patient ☐ Required or requested by recipient for purpose of ____________________

☐ Other ____________________

Expiration & Agreement

Authorization will expire 90 days from the date this Authorization is executed.

I understand that I have a right to revoke this Authorization at any time. This revocation will not affect any uses and/or disclosures already made based on this Authorization before the revocation is received by Fulgent Oncology. The revocation must be in writing and mailed to the address below. I understand that Fulgent Oncology may not condition any treatment, payment, enrollment or my eligibility for benefits on my signing this Authorization. I understand that the information used and/or disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law.

I certify that the foregoing information is true and correct.

SIGNATURE X ____________________ **DATE** ____________

PRINTED NAME ____________________

If signed by someone other than the above named patient, please describe your legal authority to act on behalf of the patient and, if applicable, attach supporting documentation.

WITNESS SIGNATURE X ____________________ **DATE** ____________

WITNESS PRINTED NAME ____________________

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