Patient 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 _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

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

☐ Other health information (please specify) _____ From _____ (MM/DD/YYYY) to _____ (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.

Please provide a copy of a government-issued identification document for authentication purposes. The completed form and accompanying ID should be faxed to Client Service at **1.855.856.0655**, sent via secure message to **info@fulgentgenetics.com**, or mailed to: 2580 Westside Pkwy, Alpharetta, GA 30004.

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 _____