BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

AUTHORIZATION FOR USE OR DISCLOSURE/RELEASE OF GENETIC INFORMATION

BACKGROUND INFORMATION

Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) ____ / ____ / ____

Baylor Genetics Lab # _____ Accession # _____ Ordering Physician _____ Institution Name _____

Phone _____ Fax _____ Date of Next Appt. (MM / DD / YYYY) ____ / ____ / ____

CHECK ALL THAT APPLY

☐ Laboratory Report (Specify test performed):

☐ Other Report (Specify):

☐ Extracted DNA Sample (Quantity Requested): _____

☐ Other Information (Specify):

☐ Tissue

Purpose of Release:

INFORMATION / SAMPLE TO BE RELEASED TO

Physician Name _____ Institution Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

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, 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 (specify below):

I hereby request the Baylor Genetics to disclose/release the information as described above. 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.

Referring Physician Signature _____ Date (MM / DD / YYYY) ____ / ____ / ____

NOTE: IF YOU ARE NOT THE REFERRING PHYSICIAN, THE "REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS" FORM WILL NEED TO ACCOMPANY THIS FORM. THE FORM SHOULD BE FILLED OUT BY THE PATIENT AND CAN BE FOUND ONLINE AT BAYLORGENETICS.COM/CONSENT/