

**PATIENT REQUEST FOR ACCESS (45 CFR §164.524)**

Patients or their personal representative can complete this form for access to or release of protected health information (PHI) and submit it via email to [info@baylorgenetics.com](mailto:info@baylorgenetics.com) or to the fax number above. Baylor Genetics will provide the requested PHI within 15 business days from receipt of the completed form unless an extension is requested.

**PATIENT INFORMATION**

____ / ____ / ____ Request Date ( MM / DD / YYYY )	Patient First Name	Patient Last Name	
____ / ____ / ____ Birth Date ( MM / DD / YYYY )	Phone	Fax	Email
Address	City	State	Zip

**PATIENT REQUEST FOR ACCESS TO OR RELEASE OF PHI TO ANOTHER**

I request that Baylor Genetics release the patient's PHI maintained by Baylor Genetics to:

The Patient or their Personal Representative

The following Person/Organization:

Name			
Phone	Fax	Email	
Address	City	State	Zip

**INFORMATION TO BE DISCLOSED, FORMAT, DELIVERY METHOD, FEES, AND EXPIRATION DATE\***

Test Results    
  Raw Data    
  Billing Records    
  Other (Please describe): \_\_\_\_\_

I understand the PHI requested to be disclosed may contain genetic information and by checking this box consent to its release.  
 (If you do not check this box, Baylor Genetics will not be able to release any records containing genetic information.)

**DATE RANGE:** To \_\_\_\_\_ From \_\_\_\_\_

**FORMAT:** Paper                      Electronic                      Other: \_\_\_\_\_

**DELIVERY:** Mail                      Fax                      Other: \_\_\_\_\_

**EXPIRES:** \_\_\_\_\_ If no date is entered, this request expires one (1) year from the date signed unless written revocation is received before then.

**SIGNATURES**

Patient Signature	____ / ____ / ____ Date ( MM / DD / YYYY )
Patient's Personal Representative Signature**	____ / ____ / ____ Date ( MM / DD / YYYY )
Printed Name	Relationship to Patient

\* Fees: A reasonable, cost-based fee for copies, including postage to mail records if requested. You will be notified of the fee before the request is processed.

\*\* Attach documentation demonstrating authority to act on behalf of the patient, if applicable (e.g., a valid power of attorney letter, court order, guardianship papers, etc.).