Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:				
Patient Name			Myriad Patient BLD #	
Current Address	City		State	Zip
Social Security Number - -	Phone Number ( )		Date of Birth / /	
This authorization is to release the protected health information to:				
Individual or Healthcare Provider Name			Myriad Provider #	
Address	City		State	Zip
Phone Number ( )	Fax Number ( )			
This authorization is to release the protected health information from:				
Myriad Genetic Laboratories, Inc. 320 Wakara Way, Salt Lake City, UT 84108			Phone / Fax (800) 469-7423 / (801) 584-3615	

The purpose of this use or disclosure is to:

- ☐ Personal use by patient.
- ☐ Provide the requested information to the healthcare provider listed above.
- ☐ Add the healthcare provider listed above to my record and send all future communications to this provider and not the previous provider listed in my record.
- ☐ Other (please specify):

Release the following information:

- ☐ Test Report *(health care providers only)*
- ☐ Itemized Billing Statement
- ☐ Other (please specify):

Date(s) of service requested:

This authorization will expire 180 days from the date signed unless otherwise specified below (requests to add a healthcare provider to my record do not expire unless this authorization is revoked):

- ☐ On the following date: ________________________
- ☐ When the following event occurs: ____

I understand that:

- every effort will be made to fulfill my request as soon as possible, but it may take up to 30 days for Myriad to process my request.
- federal regulations governing laboratories, specifically the Clinical Laboratory Improvement Amendments (CLIA), and state law do not allow Myriad to report test results directly to a patient or their personal representative. Test results should be requested from the healthcare provider who ordered the test.
- this authorization will remain in effect until the authorization expires or I provide a written notice of revocation to Myriad's Privacy Office at the address listed above. If I revoke this authorization, Myriad may not be able to reverse the use and disclosure of the health information while the authorization was in effect.
- Myriad will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.
- once Myriad discloses my health information by my request, it cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Patient or Personal Representative Signature	Date
Print Personal Representative Name *(please attach applicable legal documentation)*	Relationship to Patient

Please keep a copy of this completed form for your records.