GENOPTIX

demand definite answers.

Dear Patient,

Genoptix Medical Laboratory understands that you would like access to your laboratory test results. You will need to complete the following Authorization to Release Laboratory Test Results.

The information listed below is required and must be completed on the Authorization to Release Medical Information to release your medical information/test results:

- ☐ Patient Full Name (First Middle Last)
- ☐ Date of Birth (DOB)
- ☐ Phone Number
- ☐ Records Authorized to Be Released section
- ☐ Method of Delivery section
- ☐ Authorized Signature

Once you have completed this form, please submit this form to the Genoptix Client Services department for processing via fax or mail. Your request will be processed within 30 days from receipt.

Fax: 888-755-1604

Mail: Genoptix Medical Laboratory
Attn: Client Services
2110 Rutherford Rd
Carlsbad, CA 92008

Should you have any questions regarding this form, please contact the Client Services department for assistance at 800-755-1605.

Best,

Genoptix Medical Laboratory

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AUTHORIZATION TO RELEASE LABORATORY TEST RESULTS

Patient Full Name (First Middle Last):	**Date of Birth (DOB):**
Address:	**Phone Number:**
Referring Physician:	SSN (Last 4 digits) :
Insurance Provider :	Policy #:

I, or my authorized representative identified below, request and authorize Genoptix to release health information regarding my care and treatment as follows:

RECORDS AUTHORIZED TO BE RELEASED

Genoptix laboratory test report(s)
Date of Service(s) to include: _____(date) to _____(date)

METHOD OF DELIVERY

☐ Fax
Fax Number: _____ Attention: _____

☐ Postal Mail
Attention: _____
Address: _____
City, State, Zip _____

This authorization is effective immediately. I understand that I can revoke this authorization at any time by writing to Genoptix, Inc., but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. A copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Patient Signature, or representative authorized by law Date

_____ _____
If not patient, name of person signing form Relationship to patient

Note: If the patient is not able to sign this form, legal documents authorizing the representative to act on the patient's behalf must be provided (e.g. conservatorship, power of attorney, administrator of an estate, etc.).