PATIENT PROTECTED HEALTH INFORMATION ORDERING INSTRUCTIONS AND IMPORTANT INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Access Genetics believes that a patient's first point of contact in receiving information related to the ordering and reviewing of testing services we provided should be directly with your physician. Your physician can provide all relevant information that we received as well as a copy of your test results and thoroughly explain the procedure performed, the results and why the services were important in relation to your health condition(s). **While we can provide all of the documentation related to the services we performed, only your ordering physician can discuss the results and the meaning to your health condition(s).**

You have the right to directly obtain your test results from Access Genetics. According to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as amended 42 CFR 493.1291(l): Upon request by a patient (or the patient's personal representative), the laboratory may provide patients, their personal representatives, and those persons specified under 45 CFR 164.524(c)(3)(ii), as applicable, with access to completed test reports that, using the laboratory's authentication process, can be identified as belonging to that patient. Also as amended in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule 45 CFR 164.524(a)(1)(iii)(A)and(B).

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

To obtain this information directly from Access Genetics, complete the attached Protected Health Information (PHI) Request Form. Please include a copy of your personal identification(such as Driver License). If personal identification is unavailable, you must have your signature notarized and attach a notarial certification.

If you are a legal guardian or legal representative acting on behalf of the patient, proof of authority to act (healthcare proxy, court order, power of attorney, etc.) is required for us to process your request.

Failure to provide all of the information as required will result in our inability to provide you with the protected health information. Please assist us in protecting access to your personal information by understanding and following these procedures. Access Genetics will respond within 30 days of receipt of this request.

Should you have any questions when completing the required documentation, please contact our PHI Support Group at 855.202.6109.

Access Genetics Notice of Protected Health Information Privacy Practices is available on our website at http://www.access-genetics.com/resources/PrivacyPolicy.pdf

Patient Protected Health Information (PHI) Request Form

In order for us to identify the requested patient PHI, please complete all **required** information. Using the information provided, we will attempt to identify the laboratory tests results and or order form. *Indicates REQUIRED information.

1) Patient's Information:

Name*: _____ Phone Number: (_____) _____
First Name Middle Name/Initial Last Name

All other Names*: (nicknames, alternate spellings, former name, etc.):_____

Date of Birth*: _____
(MM/DD/YYYY)

Address*: _____

Social Security Number (last four digits)_____ Insurance ID# _____

2) Test / Order Information:

Ordering Physicians' (or Clinic) Name(s)*: _____

_____

Ordering Physician's Address(s)*: **Approximate Date(s) of Service*:**

_____ _____ (MM/DD/YY) _____ (MM/DD/YY)

_____ _____ (MM/DD/YY) _____ (MM/DD/YY)

Phone Number(s): (_____)_____

(_____)_____

Requested PHI: ☐ Laboratory Test Results ☐ Order Form

3) Requester Authorization:

By my signature below, I request that Acccess Genetics search its records and provide me or the individual I request on line 4 below, with a copy of the PHI requested. I understand that information in my health record may include information relating to Sexually Transmitted Diseases, and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing. My signature authorizes release of such information. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Unless I revoke this authorization it will expire one year from the date signed.

NOTE: If you are a legal representative of the patient please provide proof of representation as requested (healthcare proxy, court order, power of attorney, etc.).

Printed Name*: _____ ***Relationship:** (Check One)
☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Representative
*(*Proof required)* *(*Proof required)*

Signature*: _____ **Date*:** _____

4) Delivery Methods for Laboratory Test Results or Order Form Copies:

Mail to (Name)*: _____

Address (If different than above)*: _____
or
Fax Number*: _____

5) Please submit the completed form (and any *proof of representation, if required as noted above) to:

Access Genetics
7400 Flying Cloud Drive, Suite 150
Eden Prairie, MN 55344
ATTN: PHI Support Group

Or you may fax to: 952.767.1153
ATTN: PHI Support Group

Internal use: Date received: _____

Document Trace #: _____ *Initials:* _____