

**AUTHORIZATION FOR USE OR DISCLOSURE/RELEASE OF GENETIC INFORMATION**

**BACKGROUND INFORMATION**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Last Name Patient First Name MI Date of Birth (MM/DD/YY)

\_\_\_\_\_  
Baylor Genetics Lab # Accession #

\_\_\_\_\_  
Ordering Physician Institution Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Phone Fax Date of Next Appointment (MM/DD/YY)

**CHECK ALL THAT APPLY**

- Laboratory Report (Specify test performed): \_\_\_\_\_
- Extracted DNA Sample (Quantity Requested): \_\_\_\_\_
- Tissue
- Other Report (Specify): \_\_\_\_\_
- Other Information (Specify): \_\_\_\_\_

Purpose of Release:

\_\_\_\_\_

**INFORMATION/SAMPLE TO BE RELEASED TO:**

\_\_\_\_\_  
Physician Name Institution Name

\_\_\_\_\_  
Address City, State, Zip:

\_\_\_\_\_  
Phone Fax

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 Miraca Genetics Laboratories 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/YY)

**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 on our "Consent and Authorization Forms" page.**