BAYLOR GENETICS

2450 Holcombe Blvd.,
Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 1.800.411.GENE (4363)

bmgl.com

PLEASE FAX COMPLETED FORM TO: 713.798.2787

PATIENT REQUEST FOR RELEASE OF CLINICAL REPORTS AND/OR RAW DATA

Baylor Genetics will accept requests to release clinical reports and/or raw data to patients or their personal representatives only after the clinical report has been released to the ordering healthcare provider. The ordering provider will be informed of any patient requests for release of reports and/or raw data.

Clinical Reports

Baylor Genetics results are reported based on our methodology, which has been validated using our criteria, and results are interpreted by our Board Certified Directors on the date that the report is issued. Baylor Genetics is not involved with analysis or interpretation performed outside of what is included in the clinical report and is not responsible for disclosures of genetic information beyond those included in the clinical report issued by Baylor Genetics. For inquiries regarding the content of the clinical report(s), please direct your questions to your physician(s). For other questions, please contact us at 1-800-411-GENE (4363).

Raw Data

Baylor Genetics will provide the raw data related to patient's clinical report for patients and/or family members who have undergone genetic testing at Baylor Genetics, provided that the consent of each individual whose data is being requested has been obtained. Clinical reports will accompany the raw data requested. **Raw data is provided as-is and any use of the raw data by the requestor is at the requestor's own risk. The requestor is solely responsible for any interpretation and use of the data. Baylor Genetics recommends that the raw data be used for research purposes only.** Given that variability exists in bioinformatics pipelines used to analyze sequence data and generate variant lists, it is possible that research pipelines will uncover potentially "clinically relevant" discoveries not included in the Baylor Genetics clinical report. Baylor Genetics is not involved in research and is not responsible for disclosures of genetic information beyond those included in the clinical report issued by the Baylor Genetics.

INSTRUCTIONS FOR PATIENT REQUEST FOR RELEASE OF CLINICAL REPORTS AND/OR RAW DATA

In order for Baylor Genetics to release clinical reports and/or raw data to a patient or their legal representative, the following information is required:

- **Patient Verification of Identity Form**
  To be filled out by patient or patient's personal representative.

- **Request for and Consent to Release Information from Individual's Records Form**
  If a patient representative is requesting the information, documents demonstrating the representative's authority must be provided or results will not be released. If requesting only clinical reports, please fill out "PATIENT REQUEST FOR AND CONSENT FOR CLINICAL REPORT RELEASE" on page 3. If requesting both raw data and clinical reports, please fill out "PATIENT REQUEST FOR AND CONSENT FOR RAW DATA RELEASE" on page 4.

- **Payment Authorization Form**
  There is a fee for this service. The total fee will be determined once the form is completed.

Please send check payable to Baylor Genetics and fill out the Payment Authorization Form included. There is a fee of **$25** for all clinical reports available and a fee of $25 per test code for raw data with a maximum fee of **$100** per patient.

- Once all information is compiled, please fax all documentation in its entirety to **(713) 798-2787**
- Please allow up to **15 days** for receipt of clinical report(s) and **30 days** for receipt of the raw data

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PATIENT VERIFICATION OF IDENTITY FORM

This form is to be completed for each patient and/or family member requesting clinical report(s) and/or raw data.

PATIENT LAST NAME ____ PATIENT FIRST NAME ____ PREVIOUS NAME ON FILE (if applicable) ____ M.I. ____ D.O.B. (MM/DD/YY) ____

PATIENT'S PERSONAL REPRESENTATIVE (if applicable) REPRESENTATIVE LAST NAME ____ REPRESENTATIVE FIRST NAME ____ M.I. ____

I ATTEST TO BEING THE PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE AND THAT THE INFORMATION STATED ABOVE IS TRUE AND ACCURATE.

PATIENT OR PATIENT REPRESENTATIVE'S NAME ____ PATIENT OR PATIENT REPRESENTATIVE'S SIGNATURE ____ DATE (MM/DD/YY) ____

IDENTIFICATION

A photocopy of an acceptable form of identification is required for the release of the clinical report(s) and/or raw data. Please select the form(s) of identification included with this form. If a photocopy of a photo ID is not provided as proof of ID, the requestor must provide the form signed and stamped by a notary public.

Photo ID (Provide Photocopy)

- ○ Valid Driver's License from any U.S. State or Territory
- ○ Valid State ID from any U.S. State or Territory
- ○ Employer ID Card
- ○ Government ID Card

OR

○ **Notarized Documentation**

NOTARY PUBLIC

Please fill this section out if you have notarized documentation stating identity.

STATE ____ COUNTY ____

____ , personally appeared before me, and being first duly sworn declared that he/she signed this application in the capacity designated, if any, and further states that he/she has read the above application and the statements therein contained are true.

(PERSONALIZED SEAL)

NOTARY PUBLIC'S SIGNATURE ____ DATE (MM/DD/YY) ____

Note: Any forms of ID provided will be discarded by Baylor Genetics. The patient is required to provide appropriate identification and billing information each time a request is made.

FOR OFFICE USE ONLY

PATIENT IDENTIFICATION CONFIRMED BY ____ DATE (MM/DD/YY) ____

PAYMENT RECEIVED BY ____ DATE (MM/DD/YY) ____

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PATIENT REQUEST FOR AND CONSENT FOR CLINICAL REPORT RELEASE

NOTE: If requesting clinical reports AND raw data, please only fill out the "PATIENT REQUEST FOR AND CONSENT FOR RAW DATA RELEASE" on page 4.

Consent and Authorization: The execution of this form does not authorize the release of information other than that specifically described below. This form authorizes the release of information that you specify in accordance with 5 U.S.C., Section 5701 and 7332; and 45 C.F.R., parts 160 and 164.

Baylor Genetics to provide the release of clinical reports for patients and/or family members who have undergone genetic testing, provided that the consent of each individual whose data is being requested has been obtained.

PATIENT NAME ______________________ D.O.B. (MM/DD/YY) ____________ LAB# ____________

MOTHER'S NAME ______________________ D.O.B. (MM/DD/YY) ____________ LAB# ____________

FATHER'S NAME ______________________ D.O.B. (MM/DD/YY) ____________ LAB# ____________

OTHER'S NAME ______________________ D.O.B. (MM/DD/YY) ____________ LAB# ____________

Information Requested

TEST NAME	TEST CODE	DATE ORDERED	LAB # AND/OR FAMILY #

Clinical Report Delivery Via Secure Email

____
EMAIL ADDRESS

____
PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

____
INDIVIDUAL OR ORGANIZATION'S NAME TO WHOM INFORMATION IS BEING RELEASED

Authorization and Certification: (If individual is under age 18, signature of parent(s) or legal guardian is required to request report):
I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand this release may not be obtained or offered as condition for treatment, payment, or other eligibility for benefits upon my signing this authorization. I may revoke this authorization at any time in writing, except to the extent that this action has already been taken to comply with it. Written revocation is effective upon receipt by the facility housing the records. Upon release, my records will no longer be protected, and re-disclosure by those receiving the information may be accomplished without my further authorization. Without my express revocation, the authorization will automatically expire upon satisfaction of the need for disclosure, under the conditions listed above, or upon this date ____________ (supplied by individual/patient).
(MM/DD/YY)

______________________ ____________
INDIVIDUAL / PATIENT SIGNATURE DATE

______________________ ____________
MOTHER'S SIGNATURE (REQUIRED IF CLINICAL REPORT IS BEING REQUESTED) DATE

______________________ ____________
FATHER'S SIGNATURE (REQUIRED IF CLINICAL REPORT IS BEING REQUESTED) DATE

______________________ ____________
OTHER RELATIVE (REQUIRED IF CLINICAL REPORT IS BEING REQUESTED) DATE

______________________ ____________
PERSONAL REPRESENTATIVE SIGNATURE, IF NOT SIGNED BY PATIENT* DATE

*Attach documents demonstrating your authority to act on behalf of the patient.

05.2017

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PATIENT REQUEST FOR AND CONSENT FOR RAW DATA RELEASE

NOTE: If requesting only clinical reports, please only fill out "PATIENT REQUEST FOR AND CONSENT FOR CLINICAL REPORT RELEASE" on page 3.

Consent and Authorization: The execution of this form does not authorize the release of information other than that specifically described below. This form authorizes the release of information that you specify in accordance with 5 U.S.C., Section 5701 and 7332; and 45 C.F.R., parts 160 and 164.

Baylor Genetics to provide the release of raw data related to patient's clinical report for patients and/or family members who have undergone genetic testing, provided that the consent of each individual whose data is being requested has been obtained. Raw data is provided as-is and any use of the raw data by the requestor is at the requestor's own risk. The requestor is solely responsible for any interpretation and use of the data. Baylor Genetics recommends that the raw data be used for research purposes only. Clinical report(s) will be provided along with the requested raw data.

PATIENT NAME ______________ D.O.B. (MM/DD/YY) ______________ LAB# ______________

MOTHER'S NAME ______________ D.O.B. (MM/DD/YY) ______________ LAB# ______________

FATHER'S NAME ______________ D.O.B. (MM/DD/YY) ______________ LAB# ______________

OTHER'S NAME ______________ D.O.B. (MM/DD/YY) ______________ LAB# ______________

Information Requested

TEST NAME	TEST CODE	DATE ORDERED	LAB # AND/OR FAMILY #

Select Test Methodology

- ☐ **EXOME** VCF File*
- ☐ **NGS** VCF File*
- ☐ **CMA** Feature Extraction File*
- ☐ **BIOCHEM** Global MAPS Excel File*
- ☐ **FISH** Images & Score Sheets
- ☐ **CYTO** Images & Score Sheets
- ☐ **SANGER** Tracings
- ☐ **PRESEEK** Text File

***Description of File Types:**
- VCF: The Variant Call Format is a text file containing meta-information lines, a header line, and data lines each containing information about a position in the genome
- Feature Extraction File: Text file with genomic locations and probe values
- Global MAPS Excel File: List of all molecules with Z scores identified

Raw Data Delivery Via Secure Email

____
EMAIL ADDRESS

____
PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

____
INDIVIDUAL OR ORGANIZATION'S NAME TO WHOM INFORMATION IS BEING RELEASED

PATIENT ACKNOWLEGEMENT (If individual is under age 18, signature of parent(s) or legal guardian is required to request data): I understand that the raw data consists of all of my/my child's information from the genes included in the clinical report, and may include genetic information unrelated to any present health care concern. I also understand that the raw data has not been and will not be interpreted by Baylor Genetics and that the meaning of the raw data is presently unknown. I understand that any use of this data is entirely my responsibility and/or the responsibility of my health care provider.

______________ ______________
INDIVIDUAL / PATIENT SIGNATURE DATE

______________ ______________
MOTHER'S SIGNATURE (REQUIRED IF RAW DATA IS BEING REQUESTED) DATE

______________ ______________
FATHER'S SIGNATURE (REQUIRED IF RAW DATA IS BEING REQUESTED) DATE

______________ ______________
OTHER RELATIVE (REQUIRED IF RAW DATA IS BEING REQUESTED) DATE

______________ ______________
PERSONAL REPRESENTATIVE SIGNATURE, IF NOT SIGNED BY PATIENT* DATE

*Attach documents demonstrating your authority to act on behalf of the patient.

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PAYMENT AUTHORIZATION FORM

PATIENT LAST NAME ____ **PATIENT FIRST NAME** ____ **M.I.** ____

○ **AMEX** ○ **VISA**
○ **DISCOVER** ○ **MASTERCARD**

CARD # ____ **EXP. DATE** ____ **CVC** ____

NAME ON CREDIT CARD ____ **BILLING ADDRESS** ____

CARDHOLDER E-MAIL ____ **CITY** ____ **STATE** ____ **ZIP** ____

AUTHORIZED PAYMENT AMOUNT ____ **PAYMENT DATE** ____ **CARDHOLDER SIGNATURE** ____

○ **PERSONAL CHECK** **CHECKING ACCOUNT HOLDER NAME** ____

Please indicate the patient name on the check. Make check payable to Baylor Genetics.

05.2017