Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:				
Patient Name			Accession # (Optional)	
Current Address		City	State	Zip
Date of Birth	Phone Number			
This authorization is to release the protected health information to:				
Individual or Healthcare Provider Name				
Address		City	State	Zip
Phone Number	Fax Number	Email Address:		

Delivery Method (Select one):

☐ Mail ☐ Fax ☐ Email to address listed below:

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This authorization is to release the protected health information from:	
Bionano Laboratories. 2677 E. Parleys Way Salt Lake City, UT 84109	Phone / Fax: (801)931-6200 / (801)931-6201

The purpose of this use or disclosure is to:

☐ Personal use by patient.

☐ Provide the requested information to the healthcare provider listed above.

☐ Other (please specify):

Release the following information:

☐ Test Report

☐ Itemized Billing Statement

☐ Other (please specify):

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 Bionano Laboratories to process my request.
- this authorization does not grant authority to the receiving designee to make changes to my test order and only allows them to receive the information that I have specified above.
- this authorization will remain in effect until the authorization expires or I provide a written notice of revocation to Bionano Laboratories' Privacy Office at the address listed above. If I revoke this authorization, Bionano Laboratories may not be able to reverse the use and disclosure of the health information while the authorization was in effect.
- Bionano Laboratories will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.
- once Bionano Laboratories discloses my health information by my request, it cannot guarantee that the recipient will not re-disclose 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