AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:

Please print

Patient Date of Birth: Last 4 Digits of Patient SSN:

I hereby authorize **CellNetix Pathology and Laboratories** to disclose the following information/material:

To the following organization(s):

For the following purposes:

☐ At my request
☐ Other (describe):

This authorization is subject to my revocation at any time, except to the extent action has been taken in reliance thereon. Unless earlier revoked shall expire ninety (90) days from date of initial authorization or:

(Date or Event)

This authorization is effective:

☐ As of the date of authorization
☐ Other (describe):

I have the right not to sign this authorization. **CellNetix Pathology and Laboratories** will not condition treatment, payment, enrollment, or eligibility for benefits on whether this authorization is signed. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal or state confidentiality laws.

I have read and understand this authorization, have had an opportunity to have my questions answered, have signed this authorization freely, and have received a copy of this authorization.

Signature:

Patient or personal/legal representative (Attach Photo ID Date

Authority to act on behalf of patient:

(If signed by someone other than the patient, attach copy of Photo ID, Power of Attorney, etc) Date