Myriad genetics®

Patient Consent to Disclose for Treatment (state law requirement)

Myriad Genetics Laboratories, Inc., Myriad Women's Health Inc., and Assurex, Inc. (collectively "Myriad") offer a variety of genetic tests for cancer risk assessment and management, mental health and prenatal care including: BRACAnalysis CDx®, EndoPredict®, Foresight®, GeneSight®, MyChoice® CDx, MyRisk®, Precise Tumor®, Prequel®, and Prolaris®

Myriad has performed genetic testing for the patient identified below. A health care provider, other than the provider that originally ordered the test from Myriad, is requesting a copy of the patient's medical records and related information from Myriad for purposes of treatment and continuity of care. These medical records and related information may be shared under HIPAA for these purposes without patient HIPAA authorization, but certain state laws may require patient consent.

By completing this form, I consent to the disclosure of the patient's medical records and related information by Myriad to the health care provider for purposes of treatment and continuity of care.

SECTION A - PATIENT INFORMATION

Name: _____
First Middle Last

Name at time of service (if different): _____
First Middle Last

Date of Birth (MM/DD/YYYY): _____ Phone Number: _____

Current Address: _____
Street, Number, Apt. City State Zip

Address at time of service: _____
(if different) Street, Number, Apt. City State Zip

Email Address: _____

Myriad Identification No.
(accession, TRF, barcode, order, or MRN):_____

SECTION B - INFORMATION TO BE DISCLOSED

For the purpose of treatment and continuity of care, I give Myriad my consent to disclose the following medical records and information relating to the Myriad testing performed (please be as specific as possible and include names and approximate dates of service, ordering health care provider/clinic, and any other information that may assist us in locating the information to be disclosed):

_____

_____

SECTION C - RECIPIENT INFORMATION and PURPOSE

I consent for Myriad to release the medical records and information specified in Section B to: _____

_____

_____

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SECTION D - EXPIRATION AND REVOCATION

This consent does not expire, but you may revoke this consent at any time by sending a written notice of revocation of consent to Myriad Genetics, 322 North 2200 West, Salt Lake City, Utah 84116, ATTN: Privacy, or by email to privacy@myriad.com. Your revocation of consent will not apply to records that have already been disclosed. If sending by email, please be aware that email may not be a secure method of communication, in that messages may be accessed by others in transit or on your device.

SECTION E – MY UNDERSTANDING

- My decision to sign this form and consent to disclosure of medical records and related information is voluntary;
- **the medical records Myriad will disclose pursuant to this consent will include sensitive information, including genetic testing information and results;**
- Myriad does not control what the recipient of the records and related information Myriad will disclose pursuant to this consent, and it may no longer be protected by HIPAA or other applicable privacy or confidentiality laws and could be redisclosed by the recipient.

SECTION F – SIGNATURE

☐ **Patient** (Sign here if you are the Patient)

I, _____[insert patient name] have read this document and understand that by signing it, I am consenting to the disclosure of my medical records as directed on this form.

Patient Name (Please print): _____

Patient Signature: _____ Date: _____

☐ **Personal Representative** (Sign here if you are not the Patient):

I,_____ [insert name of personal representative], have read this consent and understand that by signing it, I am authorizing the disclosure of the patient's medical information as directed by this form. I represent that I am authorized to act on the Patient's behalf.

Personal Representative Name (Please print): _____

Personal Representative Signature: _____ Date: _____

Relation to the Patient (please also provide any supporting documentation, such as Court Order or Power of Attorney granting you permission to act on the patient's behalf for medical purposes): _____

_____