Treating Physician Attestation Form for Records of Deceased Individuals

I, _____, the undersigned, acknowledge that I am a licensed physician and as such request the genetic test results of the deceased individual listed below to assist in the treatment of my patient, _____. I understand that this disclosure of patient records is permissible under the Heath Insurance Portability and Accountability Act of 1996 (HIPAA) and that Myriad reserves the right to deny my request for records at their discretion.

I am requesting the records of:			
Patient Name			
Current Address	**City**	**State**	**Zip**
Phone Number	**Date of Birth** / /		
Relative requesting records for treatment purposes:			
Individuals Name			
Relationship to Deceased	**Date of Birth** / /		
To be sent to myself (Information listed below):			
Individual or Healthcare Provider Name	**Myriad Provider #**		
Address	**City**	**State**	**Zip**
Phone Number	**Fax Number**		

Delivery Method (Select one):

☐ Mail ☐ Fax ☐ Email to address listed below:

Providers Signature	**Date**