Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:			
Patient Name			Myriad Patient BLD #
Current Address	City	State	Zip
Last four digits of Social Security Number XXX - XX -	Phone Number ( )	Date of Birth / /	
Does the patient want a copy of the requested records? Yes ☐ No ☐ **Delivery Method** (Select one): ☐ Mail ☐ Fax ☐ Email to address listed below:			
This authorization is to release the protected health information to:			
Individual or Healthcare Provider Name			Myriad Provider #
Address	City	State	Zip
Phone Number ( )	Fax Number ( )	Email Address:	
Delivery Method (Select One): ☐ Mail ☐ Fax ☐ Email			
☐ Add this healthcare provider to my record and send all future communications to this provider.			
This authorization is to release the protected health information from:			
Myriad Genetic Laboratories, Inc. : 320 Wakara Way, Salt Lake City, UT 84108 * Phone: (800) 469-7423 * Fax: (801) 584-3615			
The purpose of this use or disclosure is: ☐ At the request of the individual. ☐ Other (please specify):			
Release the following information: ☐ Test Report ☐ 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:

- Myriad Genetic Laboratories relies heavily on information provided by ordering physicians at the time that laboratory tests are ordered. The information provided by my ordering physician may not be sufficient to reasonably match the information I provide on this form. In the event that Myriad is not able to reasonably match such information according to their strict criteria, they will protect patient privacy by ***NOT*** releasing the requested information.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.
- This authorization will remain in effect until the authorization expires or I provide a written notice of revocation to Myriad's Privacy Office at the address listed above. If I revoke this authorization, Myriad may not be able to reverse the use and disclosure of the health information while the authorization was in effect.
- Myriad will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.

Patient or Personal Representative Signature*	Date
Print Personal Representative Name *(please attach applicable legal documentation)**	Relationship to Patient

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of 18.*

For a deceased patient: A copy of the death certificate identifying the surviving spouse is acceptable and allows the surviving spouse to sign this authorization. Other deceased patients: a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of estate.