AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Medical Record No._____

Address: _____

I authorize The Jackson Laboratory to use or disclose my health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

_____ The entire medical record (all information)	_____ Physician and professional consult progress notes
_____ Physician's orders	_____ Diagnostic reports (lab, x-ray, etc.)
_____ History and physical, other hospital records	_____ Medication and treatment records
_____ Clinical Result report: (specify test(s))	_____ Complete Molecular Profile: (specify test(s)):
_____	_____

_____ Other: (Describe below as specifically as possible including date range as applicable).

_____

2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual or organization:

Name: _____ Address:_____

3. **Purpose of use/disclosure -** This health information will be used for the following purpose(s):

____ Initiated at the request of the patient. ____ Other (please describe):_____

4. **Expiration date/event -** Unless I specify differently, this authorization will expire (insert date or event):_____

Authorization Statements/Signatures:

5. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to The Jackson Laboratory. I understand that the revocation will not apply to information that has already been released in response to this authorization.
7. I understand that The Jackson Laboratory will not condition the provision of treatment or payment on the provision of this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Distribution of copies: Original to patient's medical record, copy to patient.