GENETICS CENTER

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REQUEST FOR MEDICAL INFORMATION/LABORATORY REPORTS FROM GENETICS CENTER FOR RELEASE TO PATIENT OR LEGAL GUARDIAN

I am requesting that medical information be released from **GENE**TICS CENTER and be forwarded to the following:

Patient or Legal Guardian:_____

Address:_____ **City**:_____ **Zip**:_____

Phone Number: _____ **Fax Number**: _____

Patient's Full Name:_____ **Date of Birth**:_____
(Last, First, M.I.)

Date of service: _____

Information Requested:

_____

_____

I hereby request, under penalty of perjury, release of medical information/records as the patient or legal guardian:

Patient or Legal Guardian (Print):_____

Patient or Legal Guardian's Signature: _____

Date: _____

Please also submit or show proof of patient identity (such as government photo identification card) **or proof of representation** (such as court order, healthcare proxy, power of attorney)**.**

Notes:
1) Genetics Center will respond to this written request within thirty (30) days of receipt of this completed form.

2) Medical entities are required to keep the requested information confidential. If the requested information is shared with non-medical third parties, the information may no longer have the same protection.

3) This request can be revoked in writing at any time, unless Genetics Center has already acted on it.

☐ I acknowledge picking up the records requested above. Signature:_____

☐ Records requested above were mailed by:_____ on (date):_____