BIOSERENITY
Smart Healthcare Solutions

Authorization for the Release of Protected Health Information

Patient Name: _____ **Last 4 digits of SSN:** _____

Previous Name: _____ **Date of Birth:** _____

Patient Address: _____

Patient Email Address: _____

Study Type: _____ **Approximate Date of Test:** _____

There will be a $6.50 charge for mailed Protected Health Information.

Requested method of delivery: ☐ **Mail** ☐ **Email** ☐ **Fax:** _____

I, or my authorized representative, hereby request that my health information that identifies me or could be used to identify me ("Protected Health Information") be released as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable state law, I understand that: I authorize the use or disclosure of any of my Protected Health Information (or that of the patient identified herein, if I am signing this Authorization as the patient's parent or personal representative) as described below, by BioSerenity USA Inc. and its affiliates ("BioSerenity").

1. I have the right to revoke this Authorization at any time by informing BioSerenity in writing of my intention to revoke this Authorization (such written notice will be sent to US-Compliance@bioserenity.com).

2. I understand that signing this Authorization is voluntary. I understand that my failure to sign this Authorization or my revocation of this Authorization will not prevent me from receiving treatment or diagnostic services or benefits that I am entitled to receive. However, I understand that in some circumstances (for example, in the case of a research study), if I do not sign this Authorization, I may not receive treatment, services, or applicable benefits.

3. Protected Health Information used or disclosed pursuant to this Authorization may be redisclosed by the recipient, and such redisclosed Protected Health Information may no longer be protected by federal or state law.

4. Protected Health Information that may be used/disclosed:

   ☐ All Protected Health Information on file, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to or received from other health care providers.

   ☐ Other: _____

   _____

   _____

I understand that any of the following sensitive data which I check will be subject to use or disclosure (unless checked in the boxes below, none of this information will be included in any use or disclosure pursuant to this Authorization):

☐ Alcohol/Drug Abuse Treatment
☐ HIV/AIDS-related Treatment
☐ Mental Health (other than psychotherapy notes)

5. Persons/entities authorized to use/disclose the Protected Health Information:

   BioSerenity, including all of its clinics, facilities, health care practitioners, and workforce.

6. Name(s) and address(es) of persons/entities by whom the Protected Health Information may be used/to whom it may be disclosed:

   _____

   _____

   _____

7. Purpose of this Authorization:

   _____

   _____

   _____

8. Unless I request in writing otherwise, I understand that this Authorization will expire on the following date or event: _____.

_____ _____

Print Patient's Name **Patient's Signature**

_____ _____

Print Authorized Representative's Name (If Applicable) **Authorized Representative's Signature**

_____

Date

I understand that a copy of this Authorization shall be provided to me upon request.

*New York residents only: If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644.

Please sign form, then FAX to 678-217-8610 ATTN: Compliance or Email to US-Compliance@bioserenity.com ATTN: Compliance.
Your records will be sent within 30 days of receipt of this form, unless applicable state law requires a shorter timeframe.