INVITAE

Authorization to Use and Disclose Health Information

FM6011-3

PATIENT INFORMATION

Name (last, first, middle initial)	Patient DOB (MM/DD/YYYY)
Address	Home phone
City, State, Zip code	Email

INFORMATION TO BE DISCLOSED

- ◯ Test requisition information
- ◯ Billing and payment records
- ◯ Genetic test results
- ◯ Entire record
- ◯ Other (specify):

RECIPIENT

1	Name or entity	Relationship to patient
	Address	Phone
	Email	Fax
2	Name or entity	Relationship to patient
	Address	Phone
	Email	Fax

DISCLOSURE PURPOSE

_____

TERM AND EXPIRATION: This Authorization will remain in effect:

- ☐ until I revoke in writing
- ☐ until Invitae fulfills this request
- ☐ until the following expiration date: _____
- ☐ until other event (specify): _____

PERSONAL REPRESENTATIVE INFORMATION (if applicable)

If you are the personal representative of the patient, complete the section below and include a copy of legal documentation that you are the parent, guardian, executor, or have medical decision-making authority.

Name	Relationship to patient
Address	Phone

Invitae and many other organizations and individuals, such as health care providers and health plans, are required to keep a person's health information confidential. I understand if the entity authorized to receive my protected health information is not legally required to keep it confidential, once Invitae discloses my health information to the recipient, my health information may no longer be protected by state and federal privacy laws and Invitae cannot guarantee that the recipient will not re-disclose my health information to a third party.

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If I have identified myself as the individual to receive the requested information, including the results of diagnostic testing, I am doing so pursuant to regulations that give me the legal right to receive the information directly. I acknowledge that the medical professional to whom Invitae has also delivered these test results is responsible for providing me with the interpretation of these test results and advising me on any treatment decisions that might be affected by these test results.

I represent that I am the individual identified as the requestor in this document and that I have the legal right to request the disclosure of the information identified in this document.

I understand that I have the right to revoke this authorization in writing at any time except to the extent that Invitae has already taken action on this authorization.

To submit this access request, contact the Privacy Officer at the following address:

Invitae Corporation, Attn: Privacy Officer, 1400 16th Street, San Francisco, CA 94103

Via phone: 415-374-7782

I hereby, knowingly and voluntarily authorize Invitae to use or disclose my health information described above.

Signature	Date

IDENTIFYING INFORMATION, ATTACHED

Examples: Driver's license, DMV identification card, birth certificate, insurance benefits card, passport

Type of identification	Identification number

IF NO IDENTIFICATION IS ATTACHED, SIGNATURE MUST BE NOTARIZED

Notary public number	Date
Notarized by	

NOTARY PUBLIC STAMP

