Authorized Protected Health Information Release Form

I am the:

- ☐ Patient
- ☐ Parent
- ☐ Legal Guardian

Patient Name or Parent/ Legal Guardian (Print) _____ Phone Number _____

Patient's full name (Print) _____ Patient's Date of Birth _____

Patient Signature _____ Date _____

I Request and Authorize (please check all):

- ☐ All information I authorize to be obtained from the laboratory will be kept in confidence. I place no limitations on the nature of information secured, including history of illness, diagnostic information or the treatment of drug abuse or psychiatric disorders.
- ☐ I consent to the inspection of the information listed above by the named facility/authorized person and as well as their ability to create and retain copies of such information.
- ☐ I understand that I may withdraw this consent at any time by submitting a withdrawal request in writing, barring State or Federal limitation. I also understand that this consent will not expire until an authorized withdrawal by the patient or their legal representative is furnished. The withdrawal of this authorization does not affect any previously disclosed PHI prior to the receipt of the withdrawal notice.
- ☐ I release Praxis Genomics LLC and its directors, agents, officers and employees from any and all liabilities, responsibilities, damages, losses and claims that might develop from the release of the information authorized above.
- ☐ I acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand them, and do expressly and voluntarily consent to the disclosure of this medical information to the individual or agency named above.

I request and authorize:

Praxis Genomics
6115 Peachtree Dunwoody Rd
Suite 220
Atlanta, GA 30328
Phone:678-620-3477

To discuss and/or release information from the medical records of the above patient. I authorize this release via phone, mail or secure email to:

Facility / Institution / Other Authorized Person _____ Physician Name _____

Address _____ City _____ State _____ ZIP _____

Phone Number _____ Fax _____ Secure Email _____

I Request and Authorize the types of records released (check all that apply):

- ☐ Clinical/Consultation Notes
- ☐ Doctor's Orders
- ☐ History/Exam Reports
- ☐ Laboratory Reports
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Specimen Release
- ☐ All Other Records