IGeneX, Inc.
Reference
Laboratory

795 San Antonio Road ● Palo Alto ● CA 94303 ● Tel: (800) 832-3200 ● Fax: (650) 424-1196

AUTHORIZATION
RELEASE FOR PROTECTED HEALTH INFORMATION

TO:

IGeneX, Inc. Reference Laboratory
795-7 San Antonio Road
Palo Alto, CA 94303
Tel: (800) 832-3200
Fax: (650) 424-1196

DATE:

NO. OF PAGES INCLUDING COVER:

SUBJECT:

AUTHORIZATION/ RELEASE FOR PHI

I, _____ hereby authorize IGeneX, Inc. Reference Laboratory to release a copy of my medical records:

PATIENT NAME: _____

ADDRESS: _____

_____

DATE OFBIRTH: _____

_____ _____
Patient/ Guardian Signature **Today's Date**

Please send copies of test results to:

DOCTOR'S NAME:_____

ADDRESS: _____

_____

PHONE NUMBER: _____

FAX NUMBER: _____

FOR OFFICE USE ONLY:

Information Verified By: _____ **Date:** _____

Requested Information faxed/ mailed by: _____ **Date:** _____