moleculera labs

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient ID #:_____

PATIENT INFORMATION					
Patient FIRST Name	Patient LAST Name	MI	Date of Birth		
			Month	Day	Year
Street Address	City	State	Zip	Primary Phone Number	

I request and authorize MOLECULERA LABS, INC. to release healthcare information of the patient named above to:

Name:					
Address:					
City:		State:		Zip:	

I request and authorize the release of the following information:

☐ Cunningham Panel of Tests Results ☐ Other (please specify): _____

I authorize the release of the requested information via:

☐ Unencrypted Email (email address): _____

☐ Mail to (address): _____

☐ Fax to (fax number): _____

☐ Other (please specify): _____

I understand that:

- **Unencrypted email** is not secure which means it could be intercepted and seen by others. In addition, I understand that there are other risks associated with unencrypted email including misaddressed/misdirected messages; email accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. Moleculera Labs is not responsible for unauthorized access to the Protected Health Information (PHI) contained in this format or any risks (e.g. virus) potentially introduced to your device when receiving PHI in electronic format.
- **It may take up to 30 days to process this request.** If this request is submitted prior to the lab results being published, it may take up to 30 days after the results have been published to process this request.
- This authorization is **valid for six (6) months** from the date signed, unless I revoke this authorization. I may revoke this authorization in writing at any time by sending written notification to Moleculera Labs at the address, fax, or email address indicated on this form. My revocation notice will not apply to actions taken prior to the date of my written request to revoke authorization.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.

_____ _____

PATIENT Signature **Date**

If you are NOT the patient but are signing on behalf of the patient, please complete the next section.

CONTINUED ON BACK

AUTHORIZATION TO RELEASE
HEALTHCARE INFORMATION
(Continued from front)

Parent/Guardian/Representative Section:

I, _____, am the (check which applies)
(Print Name)

- ☐ Parent with Parental Rights
- ☐ Court Appointed Guardian
- ☐ Medical Power of Attorney
- ☐ Surrogate Decision Maker
- ☐ Registered Kinship Care Relative
- ☐ Legally Appointed Healthcare Agent
- ☐ Power of Attorney with Right to See Medical Records
- ☐ Court Appointed Personal Representative of Deceased

_____ _____
Representative's Signature **Date**

_____ _____
Address Phone

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).

Submit completed form and proof of authority documents (if required) to Moleculera Labs at:

Moleculera Labs, Inc. · 755 Research Parkway, Suite 410 · Oklahoma City, OK 73104
· Fax: (405) 239-5255 ·
· Email: customerservice@moleculera.com ·

Questions? Contact us at: (405) 239-5250