Authorization for Access to Medical Information

Authorization to release the protected health information of:

Name: _____	Date of Birth: MM _____/DD _____/YYYY _____
Address: _____	Phone: _____
City, State, Zip: _____	Email: _____

This authorization is to release the protected health information to:

Name: _____	Phone: _____
Address: _____	Fax: _____
City, State, Zip: _____	Email: _____

This authorization is to release the protected health information from:

NeoGenomics Laboratories, Inc.	Phone: 866.776.5907	Fax: 239.690.4237

The purpose of this use or disclosure:

☐ Personal ☐ Insurance ☐ Attorney ☐ Continuing Care ☐ Other: _____

Release the following information:

☐ Lab/Path Report ☐ Itemized Billing Statement ☐ Other (Please specify): _____

Date of service or range of service: _____

Method of delivery:

☐ U.S. Mail to: _____

☐ Fax: (_____) _____ - _____ ☐ Email: _____

This authorization will expire 1 year from the date signed unless otherwise specified below:

☐ On the following date: _____

☐ When the following event occurs: _____

I understand that:

- This authorization is voluntary and I may refuse to sign this authorization.
- By signing this authorization, my ability to obtain treatment, receive payment, or eligibility for benefits, will not be affected, unless allowed by law.
- I have the right to revoke this authorization in writing. If I revoke this authorization (see below), NeoGenomics Laboratories, Inc. may not be able to reverse the use and disclosure of the health information while the authorization was in effect.
- By signing this authorization form, the information being released may no longer be protected by HIPAA once disclosed.
- This authorization may include disclosure of information related to alcohol and drug abuse, mental health treatment, and confidential HIV related information.
- If these records contain any information from previous providers or information about HIV/AIDS status or cancer diagnosis, you are hereby authorizing the disclosure of this information.
- By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of the aforementioned health information. There are no claims or court orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.
- Every effort will be made to fulfill my request as soon as possible, but it may take up to 30 days for NeoGenomics Laboratories, Inc. to process this request.

_____ Patient or Personal Representative Signature

_____ Date

_____ Printed Patient or Personal Representative Name

_____ Relationship to Patient

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***MUST PROVIDE A COPY OF A VALID ID*
*(DRIVER'S LICENSE/IDENTIFICATION CARD/MILITRY ID/ETC) FOR SIGNATURE VERIFICATION***

*** If a person other than the patient is signing, a copy of legal paperwork verifying the validity of the patient's personal representative MUST accompany this request. (i.e. court appointed guardian, durable power of attorney for health care) Exception: Parent's signing for a patient under the age of 18.***

*** For Authorization revocation please submit your written request to the Compliance Department:*

NeoGenomics Laboratories
Compliance Department
12701 Commonwealth Dr., Suite 9
Fort Myers, FL 33913
compliance@neogenomics.com

Signed authorization form is to be submitted via fax or mail

Fax *239.690.4237*

Mail *12701 Commonwealth Dr., Suite 9*
Fort Myers, FL 33913

12701 Commonwealth Dr., Suite 9
Fort Myers, FL 33913
Phone: 866.776.5907/ **Fax:** 239.690.4237
neogenomics.com