BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

PATIENT REQUEST FOR ACCESS (45 CFR §164.524)

Patients or their personal representative can complete this form for access to or release of protected health information (PHI) and submit it via email to help@baylorgenetics.com or to the fax number above. Baylor Genetics (BG) will provide the requested PHI within 15 business days from receipt of the completed form unless an extension is requested.

PATIENT INFORMATION

_____ / _____ / _____ Request Date (MM / DD / YYYY)

Patient First Name

Patient Last Name

_____ / _____ / _____ Birth Date (MM / DD / YYYY)

Phone

Fax

Email

Address

City

State

Zip

PATIENT REQUEST FOR ACCESS TO OR RELEASE OF PHI TO ANOTHER

I request that BG release the patient's PHI maintained by BG to:

◯ The Patient or their Personal Representative

◯ The following Person/Organization:

Name

Phone

Fax

Email

Address

City

State

Zip

INFORMATION TO BE DISCLOSED, FORMAT, DELIVERY METHOD, FEES* AND EXPIRATION DATE

☐ Test Results ☐ Raw Data ☐ Billing Records ☐ Other (Please describe): _____

☐ I understand the PHI requested to be disclosed may contain genetic information and by checking this box consent to its release. (If you do not check this box, BG will not be able to release any records containing genetic information.)

DATE RANGE: To _____ From _____

FORMAT: ◯ Paper ◯ Electronic ◯ Other: _____

DELIVERY: ◯ Mail ◯ Fax ◯ Other: _____

EXPIRES: _____ If no date is entered this request expires one (1) year from the date signed unless written revocation is received before then.

***Fees:** A reasonable, cost-based fee for copies, including postage to mail records if requested. You will be notified of the fee before the request is processed.

SIGNATURES

Patient Signature

_____ / _____ / _____ Date (MM / DD / YYYY)

Patient's Personal Representative** Signature

_____ / _____ / _____ Date (MM / DD / YYYY)

Printed Name

Relationship to Patient

**Attach documents demonstrating your authority to act on behalf of the patient if you are not the parent (e.g., A valid power of attorney letter, court order; guardianship papers).