Neurome Raw Data Patient Authorization

athena diagnostics

Patient's Information (Required):

1. Name: _____
First Name Middle Name/Initial Last Name

Provide All Other Names (Nicknames, Alternate Spellings, Former Name, etc.): _____

Provide Two of the Following Level One Identifiers and One Level Two; or One Level One Identifier and Two Level Two Identifiers

Level One Identifiers:

2. Date of Birth: _____ 3. Phone Number: _____

4. Social Security Number (Last Four Digits): _____

Level Two Identifiers:

5. Patient's Address (Street, City, State, Zip): _____

6. Insurance ID Number: _____ 7. Patient Invoice Number: _____

8. Ordering Provider's Name (Or Practice Name): _____

9. Ordering Provider's Address: _____

10. Ordering Provider's Phone: _____ 11. NPI Number: _____

☐ **PUC Code: 1504 - Neurome Raw Data (FASTQ and .vcf)** ☐ **PUC Code: 1508 - Neurome .vcf Data**

☐ **PUC Code: 1504 - Neurome Raw Data (.bam and .vcf)**

PHI Type (Required): ☐ Raw Sequence Data **Date(s) of Service:** _____

Signature: I Have Reviewed This Document And My Authorization Is Below.

Name (Please Print): _____

Signed: _____ Date: _____
Patient

Or By: _____ Date: _____
Patient's Representative

Description of Representative's Authority: _____
(Required: Documentation of the Representative's Authority Must be Attached. Note: Parents of Minors do not Need to Provide Documentation.)

Patient Revocation (to be signed only if you wish to revoke the Authorization, except to the extent that we have already relied on this Authorization to use or disclose your information).

I hereby revoke this authorization to use and/or disclose my protected health information. This revocation is effective on the date that it is signed below, and Athena Diagnostics may not use or disclose my protected health information that is subject to this authorization after this date. I understand that if Athena Diagnostics has previously relied upon this authorization to use and/or disclose my PHI, that such previous use and/or disclosure may not be revoked.

Signed: _____ Date: _____

Institutional Billing

Facility Name: _____

Contact Name: _____ Phone: _____

Address (Street, City, State, Zip): _____

Please Send the Requested Information to the Following (Client to Fill Out):

Name: _____ Title: _____

Address: _____ Phone Number: _____

Or Fax: _____ Or Email (Please Print): _____

Patient Authorization
To Use and Disclose Protected Health Information (PHI)

I authorize Athena Diagnostics (including its affiliates and subsidiaries) to use and/or disclose my protected health information (for example, my laboratory test results, billing information and/or other related medical information) including but not limited to raw sequence data generated from the Neurome Test, a DNA sequencing analysis of the whole exome particularly targeted to regions in neurological disorders, as specifically identified above, to the person(s) named in this request. I understand that this authorization will expire when Athena Diagnostics has provided the requested information.

The raw sequence data requested by my physician will be used for research purposes approved by an Institutional Review Board and may contain personal identifying information and genetic information about regions of genes tested from my or my child's sample. I understand several layers of analysis are typically necessary to convert raw sequence data into an understanding of their functional application in health and disease. The raw sequence data will be encrypted and can be provided on a physical hard drive or it may be accessed via a secure internet server. Raw sequence data may be provided as electronic data file formats such as FASTQ and VCF formats. This disclosure of my PHI is a sale of PHI under HIPAA. Athena Diagnostics will receive payment and/or other remuneration in exchange for disclosing my PHI.

I authorize attorney(s) and their legal staff, as well as appropriate Athena Diagnostics employees, to use and/or disclose my PHI in accordance with this authorization.

This use and/or disclosure of my PHI is at my own request. I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the person or party receiving it; in that case, the information may no longer be protected under federal privacy law.

Notice to the Patient:

If we are requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services to you on the receipt of this signed authorization *except* if you are participating in a research project;
- You may request a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization;
- We must provide you with a copy of the signed authorization, upon request;
- This authorization only covers PHI that is used or disclosed by Athena Diagnostics. The information could be redisclosed by the person(s) who receive it and, in that case, your PHI will not be protected by the HIPAA privacy and security rules: and
- You have the right to revoke this authorization at any time, provided that you do so in writing, except to the extent that we have already relied on this authorization to use or disclose your information.

For Internal Use Only:

Athena Diagnostics
200 Forest Street, Suite 200
Marlborough, MA 01752
IRB #: _____