FAMILY INSIGHT PROGRAM

HIPAA AUTHORIZATION TO DISCLOSE PHI

I authorize Athena Diagnostics, Inc., its parent, subsidiaries or affiliates ("Athena") to use, disclose and disseminate my protected health information, or PHI, collected in connection with the Family Insight Program, to the "Authorized Persons" (listed below) for the following purpose: classifying a genetic variant of my relative that is of unknown significance. Athena will cover the cost of my Family Insight genetic testing. However, I understand that this testing is not intended to be used for my medical care; rather, the testing is intended for my relative's medical care. Therefore, I understand that I will not receive the results of my Family Insight Program test, except as required by law.

"**PHI**" consists of the following protected health information: my genetic testing results, other family history, or information about me that my relative's healthcare provider gives to Athena as part of the Family Insight Program, my age, and my status as a parent or other familial relation to my relative who has requested that I participate in the Family Insight Program to assist with their medical care. "**Authorized Persons**" include: my relative's healthcare providers and my relative or their legal guardian.

I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the person or party receiving it and will no longer be protected under HIPAA (a federal medical privacy law). I understand that my results will likely become part of my relative's medical record and therefore may be re-disclosed to others by my relative, by Athena, or by my relative's healthcare provider when/if they disclose my relative's medical records.

This authorization becomes effective upon my signature and will not expire until I revoke this authorization or such earlier time as required by state law.

Notice to the patient:

- **This authorization is optional. You may refuse to sign it, however it is required for participation in the Family Insight Program**
- If you choose not to sign this consent, it will not impact your ability to receive other Athena testing services. If you wish to have Athena perform genetic testing for your own medical care, please discuss this option with your healthcare provider
- Athena must provide you with a copy of this signed authorization, upon request
- You have the right to revoke this authorization at any time, provided that you do so in writing. Send your notice of revocation to the attention of the Family Insight Program at familyinsightprogramrevocationrequests@questdiagnostics.com. In your request state: "I, (your name, date of birth), wish to revoke the authorization to use, disclose and disseminate my "PHI" collected in connection with the Family Insight Program to persons stated in the Family Insight Program HIPAA Authorization to Disclose PHI form." Include your family member's name, date of birth, and the gene/variant tested. Please note, your revocation only applies to the use of your information after we receive the revocation and does not affect any prior use or disclosure made in reliance upon this authorization prior to your revocation.

My Demographic Information:

1. Print Name: _____
2. Date of Birth: _____
3. Phone Number: _____

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

My Family Member's (original patient tested) Information:

1. Print Name: _____
2. Date of Birth: _____
3. Gene/Variant tested: _____

I have read and understand this authorization and authorize the use, disclosure and dissemination of my PHI as set forth above.

Signed: _____ Date: _____

(Authorizing Individual's signature or their Representative)

Description of Representative's Authority _____

(NOTE: Documentation of Representative's authority **must** be attached, except parents of minors need not provide documentation.)