AUTHORIZATION FOR
RELEASE OF PROTECTED HEALTH INFORMATION

TO:

IGeneX, Inc. Reference Laboratory
556 Gibraltar Dr.
Milpitas, CA 95035
Tel: (800) 832-3200
Fax: (408) 935-8272

DATE:

NO. OF PAGES INCLUDING COVER:

SUBJECT:

I, _____ hereby authorize IGeneX, Inc. Reference Laboratory to release a copy of my medical records:

PATIENT NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

_____ _____
Patient/ Guardian Signature **Today's Date**

Please send copies of test results to:

DOCTOR'S NAME:_____

ADDRESS: _____

_____

PHONE NUMBER: _____

FAX NUMBER: _____

FOR OFFICE USE ONLY:

Information Verified By: _____ **Date:** _____

Requested Information faxed/ mailed by: _____ **Date:** _____