The HudsonAlpha CLINICAL SERVICES LAB

HudsonAlpha Clinical Services Lab, LLC
601 Genome Way, Rm 3001
Huntsville, AL 35806
256-327-9670 ● info@clinicallab.org

RELEASE OF RECORDS REQUEST AND AUTHORIZATION FORM

1. Data Release

A. I authorize the **HUDSONALPHA CLINICAL SERVICES LAB, LLC** to disclose information from the health records of:

Name: ______________________________ Date of Birth: ______________

B. The information is to be disclosed to: (*insert SELF if applicable*):

Name: ______________________________

Address: ______________________________ City: ______________________________

State: ______ Zip: ______________ Phone: ______________ Fax: ______________

Email: ______________________________

C. Purpose or need for the disclosure: ______________________________

D. Specific record(s) to be disclosed:

❏ Laboratory Test Reports
❏ Genomic Data (FASTQ, BAM, and/or VCF) - complete **Section 3**
❏ Other (*specify*): ______________________________

E. I authorize this information to be disclosed and delivered in the following way(s):

❏ Fax (Laboratory Test Reports)
❏ Encrypted email (Laboratory Test Reports)
❏ Written/photocopy/paper (Laboratory Test Reports)
❏ Encrypted hard drive (Genomic Data only**)
❏ Secure file transfer (Genomic Data only**)

F. Responsible party for payment *(required for encrypted hard drive and secure file transfers only)***:**

Name: ______________________________ Phone: ______________________________

**A request form must be completed for each sample to be released. The cost for an encrypted hard drive is $160 for the first sample and $30 for each additional sample. The cost for secure file transfer is $85 for the first sample and $30 for each additional sample. Data released via secure file transfer will be available for download for 30 days.

2. Restrictions *(please initial)*

______ Treatment, payment, or other eligibility for benefits will not be based on the completion and execution of this authorization and consent form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or state privacy regulations.

______ I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying **HUDSONALPHA CLINICAL SERVICES LAB, LLC** in writing at 601 Genome Way, Room 3001, Huntsville, AL 35806. Written revocation is effective upon receipt by the releasing entity.

______ Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, or in one year unless I specify another time here: ______________ (*supplied by individual/patient*)

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3. Release of Sequencing Data *(please initial)*

_______ Sequencing data provided include sequencing reads and/or variant calls that do not pass quality thresholds in place at **HUDSONALPHA CLINICAL SERVICES LAB, LLC**. These thresholds are designed to prevent the reporting of false positive results. Variants identified only in raw (unprocessed) data and not included in the Laboratory Test Report should not be acted upon or used for clinical decision making without discussion with **HUDSONALPHA CLINICAL SERVICES LAB, LLC** due to the likelihood that such variants may be false calls.

_______ Sequencing data provided includes all variants regardless of medical significance (pathogenic or benign). Variant pathogenicity is not included in the requested genomic data. Refer to the interpreted Laboratory Test Report from **HUDSONALPHA CLINICAL SERVICES LAB, LLC** (if available) for variant classification.

4. Consent

Note: The execution of this form does not authorize the release of information other than that specifically described above.

I release **HudsonAlpha Clinical Services Lab, LLC** from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Check one of the following:

❏ I am the patient for whom the data is being requested.

❏ I have legal authority to request the data for the patient listed in this request.

_______________________________________	_______________________
Signature of Patient or Patient Representative	Date
Printed Name of Patient or Patient Representative	Relationship of Representative to Patient

Submit completed form to:
Email: info@clinicallab.org
Fax: 256-327-9760
Mail: HudsonAlpha Clinical Services Lab, LLC
601 Genome Way, Room 3001
Huntsville, AL 35806

For questions:
Email: info@clinicallab.org
Phone: 256-327-9670