# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Government issued photo ID must accompany this form.

**Patient Name:** _____ Date of Birth: _____ Phone: _____

Address _____ City _____ State/Province _____ Zip/Postal Code _____

**Ordering Physician/Practice Name:** _____ Phone: _____

Address _____ City _____ State/Province _____ Zip/Postal Code _____

**Requested Information**

I authorize the disclosure of the following Protected Health Information (PHI):

☐ Billing Records ☐ Lab Reports ☐ Entire Designated Record Set

☐ Other (please specify exact information) _____

**Delivery Preference for Patient**

☐ Email copies to _____

☐ Hard copies sent to address above

☐ Other _____

**Purpose of the Requested Use or Disclosure**

☐ At the request of the patient

☐ Share with another practitioner
Practitioner Name: _____ Practitioner Email: _____

☐ Allow another practitioner to consult with a Cyrex clinician
Practitioner Name: _____ Practitioner Email: _____

☐ Other (Indicate specific reason): _____

**Please note the following:**

1. You may inspect and obtain copies of the Protected Health Information to be used or disclosed. You may refuse to sign this Authorization. Your refusal will not affect your ability to obtain treatment or payment.
2. If the persons or entities that are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
3. Once this authorization is signed, it is valid until revoked or expired. You may revoke the authorization by mailing a signed and dated letter to:

   **Cyrex Laboratories**
   Attn: Customer Service
   2602 S. 24th St.
   Phoenix, AZ 85034

**This authorization expires in one year.**

Signature: _____ Date: _____ Time*: _____
*if signed electronically, time of signature is required.

Relationship or Authority of Personal Representative (if applicable): _____