Santa Clara Family Health Plan™

Authorization for Release of Genetic Test Results

Name of Patient	Date of Birth	Social Security #

1. *I hereby authorize* _____ (M.D., agency or institution) to furnish medical information concerning GENETIC TEST RESULTS for the above patient to:

   _____
   (Name & address of receiving person, agency or institution)

2. *I authorize* the following information to be released:

   _____

   _____

3. *I authorize* that the information collected may be used for only the following purposes:

   _____

   _____

4. *I authorize* the following persons or entities to have access to the above information:

   _____
   (Name or function of the persons or entities authorized to have access to the above medical information)

5. This authorization to release records is effective _____ (today's date), and the authorization will remain effective for sixty (60) days from this date.

6. *I understand* that written authorization is required for each separate disclosure of the test results, and that the receiving person/entity will not further release these records without my additional consent.

7. *I understand* that I have the right to receive a copy of this authorization, and I understand that the information will not be used for any purpose other than its intended use as noted above.

Patient Signature: _____ **Date:** _____

Parent/Guardian/Conservator Signature: _____

Please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient