Authorization to Release Test Results to a Designated Third Party

The purpose of this form is to authorize Foundation Medicine to release patient information or test results to a designated third party. Per the Health Insurance Portability and Accountability Act (HIPAA), Foundation Medicine is required to obtain written authorization by the patient.

1. Complete the Patient Information below. This should include patient name, date of birth, and ordering physician.
2. Provide the name and contact information (i.e., email address or fax number) for the third party who will be receiving the test results.
3. Print, sign and date the form.
4. Fax the form to 1 (617) 418-2290 or email to client.services@foundationmedicine.com. Upon receipt of the form, test results will be issued to the designated third party in the preferred method listed below.

Patient Information

I, _____ (print name), authorize Foundation Medicine, Inc. to release my test results to the individual(s) listed below.

This authorization will expire on _____ (REQUIRED: Enter specific date (mm/dd/yyyy) or defined event). I have the right to revoke this authorization in writing at any time, except to the extent that Foundation Medicine has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Foundation Medicine
Attn: Privacy Officer (Compliance Department)
150 Second St. Cambridge, MA 02141

I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer by protected by HIPAA's Privacy Rule.

Date of Birth (MM/DD/YYYY) _____

Foundation Medicine Case Number _____

Ordering Physician _____

Designated Third Party

Name	Email Address or Fax Number

Patient Signature _____

Date (MM/DD/YYYY) _____

EMAIL TO:

Email: client.services@foundationmedicine.com

FAX TO:

Fax: +1 (617) 418-2290

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