Request for Access to Medical Information Form

To request access to your medical information that Foundation Medicine, Inc. maintains, including medical and billing records and other records, please complete this form.

PATIENT INFORMATION Please complete the following information:

Last Name[1] **First Name**[1] **Date of Birth**[1] **Phone**[2]

Postal Address[2] **Email Address**[2]

Ordered Test Number(s) (if known) **Test report date(s) (if known)** **Ordering Physician**

Signature of Patient or Personal Representative[1] **Date of Request**[1]

☐ Check box if you are signing as the personal representative of the patient and complete this section, including attaching the relevant requested documentation.

Personal Representative First and Last Name

Relationship of Personal Representative to Patient

Phone and/or Email Address of Personal Representative

Description of Personal Representative Authority
(please attach a copy of any relevant supporting documentation, such as a health care power of attorney or guardianship papers)

INFORMATION ABOUT YOUR REQUEST

Please select the information you are requesting:

☐ **Medical Records** ☐ **Billing Records** ☐ **FMI Test Results Only** ☐ **Other (please specify)**

Please provide the period for which you are requesting this information (check only one):

☐ **From the period from** _____ **to** _____ ☐ **Up until the date of this request**

PLEASE INDICATE YOUR PREFERRED METHOD FOR RECEIVING THE INFORMATION (Check only one)

Please select the preferred method for notifications and provide the information below:

☐ **Electronic Mail*** If checked, provide email address:

**While we use secure email, there is some level of risk that your information could be accessed by a third party. By choosing this method, you are confirming that you understand the risk and still want to receive your information by email.*

☐ **Facsimile** If checked, provide fax number: _____ ☐ **Mail** If checked, provide address:

☐ **Access** If checked, indicate at which FMI location (check one) you would like us to arrange for you to access and review the requested information:

☐ 150 Second Street, Cambridge, MA 02141 ☐ 7010 Kit Creek Road, Morrisville, NC 27560 ☐ 11010 Torreyana Road, San Diego, CA 92121

☐ **Other** Please specify other method:

PLEASE SEND THIS COMPLETED FORM

By email to: **privacy@foundationmedicine.com** By fax to: **617.418.2290** Or by mail to: **Foundation Medicine, Inc.**
Attn: Privacy Officer
150 Second St, Cambridge, MA 02141

1. Required information.
2. You must provide at least one of these fields so that we can contact you.

FOUNDATION MEDICINE®

www.foundationmedicine.com | Tel 888.988.3639 | Fax 617.418.2290 | US-PF-2200048