

Patient Medical Records Release Form



I authorize Natera to disclose medical information, called **Protected Health Information or PHI**, as directed in this form.
Please do NOT attach or send identification documents (e.g., license or other picture ID) with this request form.

A. PATIENT INFORMATION

The Patient whose PHI is to be disclosed is:

Name: _____
First Middle Last

Name at time of service (if different): _____
First Middle Last

Date of Birth (MM/DD/YYYY): _____ Phone Number: _____

Current Address: _____
Street Name Apt./Suite

City State Zip

Address at time of service (if different): _____
Street, Number, Apt. City State Zip

Email Address: _____

B. INFORMATION TO BE DISCLOSED

Test Name: _____ Approximate Date of Service: _____

Test Name: _____ Approximate Date of Service: _____

Other (please be as specific as possible, and include information that will assist us in identifying the records being requested):

C. RECIPIENT AND PREFERRED METHOD FOR DELIVERY OF THE INFORMATION

I authorize Natera to release the Patient's PHI specified in Section B to:

Patient Other _____
First Middle Last

Preferred method of delivery:

Mail (Street address, Apt/Suite, City, State, Zip): _____

Email: _____ Fax: _____
Email address Number (xxx) xxx-xxxx

* If Email is chosen, **Natera will send the information using a secure encrypted platform** (for unencrypted email, see below).

I acknowledge by checking this box that I wish the information to be sent to me through **unencrypted email**, recognizing that there is risk that an unauthorized person can access or view a regular email, either in transit or while in my email inbox.

D. MY UNDERSTANDING

I understand:

- This Authorization is voluntary, and that Natera will not condition treatment, payment for services, or eligibility for services on whether I sign this Authorization.
- Natera has no responsibility for the security, privacy or confidentiality of the information once disclosed and in Recipient’s possession. The information disclosed pursuant to this Authorization may no longer be protected by HIPAA or other applicable privacy or confidentiality laws and could be redisclosed by the Recipient.
- This Authorization expires upon fulfillment of the request (or other final disposition of the request).

E. SIGNATURE

Patient (Sign here if you are the Patient and are submitting this Authorization on your own behalf)

I have read this Authorization and understand that by signing it, I am authorizing the disclosure of my PHI as directed on this form.

Patient Name (Please print): _____

Patient Signature: _____ Date: _____

*IF SIGNED BY PATIENT, ADDITIONAL IDENTITY DOCUMENTS ARE **NOT** REQUIRED. IF THERE ARE QUESTIONS REGARDING IDENTITY FOR PURPOSES OF FULFILLING THIS REQUEST, NATERA WILL CONTACT YOU DIRECTLY.*

Parent or **Guardian requesting on behalf of a minor**

Name of Parent/Guardian (Print Full Name): _____

Signature of Parent/Guardian: _____

IF YOU ARE THE PARENT OR GUARDIAN OF A MINOR YOUR RIGHT TO RECEIVE ACCESS TO THE INFORMATION REQUESTED WILL DEPEND UPON STATE LAW AND THE AGE OF THE MINOR AT THE TIME OF THIS REQUEST.

Personal Representative (Sign here if you are not the Patient)

I, _____ [Insert name of personal representative], have read this Authorization and understand that by signing it, I am authorizing the disclosure of the Patient’s PHI as directed by this form. I represent that I am authorized to act on the Patient’s behalf.

Personal Representative Name (Please print): _____

Personal Representative Signature: _____ Date: _____

Relation to the Patient: _____

PLEASE PROVIDE SUPPORTING DOCUMENTATION, SUCH AS A HEALTHCARE PROXY, COURT ORDER, LEGAL GUARDIANSHIP PAPERS, LIVING WILL OR LETTERS OF APPOINTMENT, POWER OF ATTORNEY GRANTING YOU PERMISSION TO ACT ON THE PATIENT’S BEHALF FOR MEDICAL PURPOSES, ETC.

F. WHERE TO RETURN COMPLETED FORMS

For **Prospera** or **Renasight** Tests (Organ Health), please email to organhealthcares@natera.com, or fax to (650) 412-1974

For **Altera** or **Signatera** Tests (Oncology), please email to oncologyce@natera.com, or fax to (650) 412-1962

For **Panorama**, **Horizon**, **Vistara**, **Spectrum**, **Empower** or **Anora** Tests (Women’s Health), please email to medicalrelease@natera.com, or fax to (650) 412-0847

If you don’t recall the Test name, please email to medicalrelease@natera.com