moleculera biosciences
a precision medicine company

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

For Moleculera Use Only

Patient ID #:_____

PATIENT INFORMATION					
Patient FIRST Name	Patient LAST Name	MI	Date of Birth		
			Month	Day	Year
Street Address	City	State	Zip	Primary Phone Number	

I request and authorize MOLECULERA BIOSCIENCES, INC. to release healthcare information of the patient named above to:

Recipient's First and Last Name: _____

I request and authorize the release of the following information:

☐ Autoimmune Brain Panel™ (formerly known as the Cunningham Panel™)

☐ Other (please specify): _____

I authorize the release of the requested information via (*choose one*):

☐ Unencrypted Email (print email address): _____

☐ Mail – **Fees apply** (print address): _____

☐ Fax (print fax number): _____

☐ Other (please specify): _____

I understand that:

- **Unencrypted email** is not secure which means it could be intercepted and seen by others. In addition, I understand that there are other risks associated with unencrypted email including misaddressed/misdirected messages; email accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. Moleculera Biosciences is not responsible for unauthorized access to the Protected Health Information (PHI) contained in this format or any risks (e.g. virus) potentially introduced to your device when receiving PHI in electronic format.
- If I selected the **MAIL** option, I will incur fees which will be required to be paid when I submit this request.
- **It may take up to 30 days to process this request.** If this request is submitted prior to the lab results being published, it may take up to 30 days after the results have been published to process this request.
- This authorization is **valid for one (1) year** from the date signed, unless I revoke this authorization. I may revoke this authorization in writing at any time by sending written notification to Moleculera Biosciences at the address, fax, or email address indicated on this form. My revocation notice will not apply to actions taken prior to the date of my written request to revoke authorization.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.

_____ _____

PATIENT Signature **Date**

If you are NOT the patient but are the parent/guardian/representative, please complete the next section.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(Continued from previous page)

CONTINUED ON NEXT PAGE

Parent/Guardian/Representative Section:

I, _____, am the (check which applies)
(Print Name)

☐ Parent with Parental Rights
☐ Court Appointed Guardian
☐ Medical Power of Attorney
☐ Surrogate Decision Maker
☐ Registered Kinship Care Relative
☐ Legally Appointed Healthcare Agent
☐ Power of Attorney with Right to See Medical Records
☐ Court Appointed Personal Representative of Deceased

I acknowledge and agree to the statements in the "I understand that" section on the previous page.

_____ _____
Representative's Signature **Date**

☐ Check here if your address and phone number are the same as the patient's listed on page 1 of this form.
If not, please provide your address and phone number below.

_____ _____
Address Phone

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).

Submit completed form and proof of authority documents (if required) to Moleculera Biosciences at:

Moleculera Biosciences, Inc. · 755 Research Parkway, Suite 410 · Oklahoma City, OK 73104
· Fax: (405) 239-5255 ·
· Email: customerservice@moleculera.com ·

Questions? Contact us at: (405) 239-5250