

## EXOME SEQUENCING HIPAA AUTHORIZATION TO DISCLOSE PHI

I authorize Quest Diagnostics Incorporated and its subsidiaries and affiliates (“Quest”) to use, disclose, and disseminate my protected health information, or PHI, collected in connection with Exome Sequencing test, to the “Authorized Persons” (listed below) for the following purpose: interpretation of my relative’s genetic data. I understand that this testing is intended for my relative’s medical care and that I may not receive the results of the exome sequencing test, except as required by law.

“PHI” consists of the following protected health information: my genetic testing results, other family history, information about me that my relative’s healthcare provider gives to Quest as part of exome sequencing testing, my age, and my status as a parent or other familial relation to my relative. “Authorized Persons” include my relative’s healthcare providers and my relative or their legal guardian.

I understand that the information used and/or disclosed pursuant to this authorization may be redisclosed by the person or party receiving it and will no longer be protected under HIPAA (a federal medical privacy law). I understand that my results will likely become part of my relative’s medical record and therefore may be redisclosed to others by my relative, by Quest, or by my relative’s healthcare provider when/if they disclose my relative’s medical records. This authorization becomes effective upon my signature and will not expire until I revoke this authorization or such earlier time as required by state law.

### Notice to the patient:

- This authorization is optional. You may refuse to sign it. However, it is required for your participation in exome sequencing testing.
- If you choose not to sign this consent, it will not impact your ability to receive other Quest testing services. If you wish to have Quest perform genetic testing for your own medical care, please discuss this option with your healthcare provider.
- Quest must provide you with a copy of this signed authorization upon request.
- You have the right to revoke this authorization before your relative’s testing has begun processing in the laboratory, provided that you do so in writing. Send your notice of revocation to the attention of [HIPAArevocation@questdiagnostics.com](mailto:HIPAArevocation@questdiagnostics.com). In your request, state: “I, (your name, date of birth), wish to revoke the authorization to use, disclose, and disseminate my “PHI” collected in connection with exome sequencing testing to persons stated in the HIPAA Auth to Disclose PHI form.” Include your family member’s name and date of birth. Please note, your revocation only applies to the use of your information after we receive the revocation and does not affect any prior use or disclosure made in reliance upon this authorization prior to your revocation.

### My demographic information:

Print name: \_\_\_\_\_ date of birth: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address (Street, City, State, Zip): \_\_\_\_\_

My familial relationship to my relative (person having exome testing): \_\_\_\_\_

Print relative’s name: \_\_\_\_\_

Relative’s Date of Birth: \_\_\_\_\_

I have read and understand this authorization and authorize the use, disclosure, and dissemination of my PHI as set forth above.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*(Authorizing individual’s signature or their representative)*

Description of representative’s authority \_\_\_\_\_