Authorization for Release
Health information - genomic sequencing test data

Patient Information			
Last (family) Name	First Name	MI	Date of Birth _____/_____/_____ Month Day Year
Medical Record Number OR Alamya Health ID Number (If available)			

Information to Release	
Sequencing Raw Data	☐ BAM ☐ VCF

Release To			
If patient, indicate “self”			
Person or Healthcare Provider Name	Institution		
Address	City	State	Zip
Email Address	Phone Number	Fax Number	

Patient or patient representative's signature is not required if this request is from the original ordering healthcare provider.

If the request for the raw data is made by someone other than the original ordering provider, this must be authorized by the patient below.

Authorization
I authorize Alamya Health to release genomic sequencing raw data as detailed above to the named person or healthcare provider. This authorization is voluntary. My treatment will not be impacted by my request for this release of information. If I do not sign this authorization, Alamya Health will not release the information. I will retain a signed copy of this authorization. _____ _____ _____ Patient/Legal Decision Maker Signature Printed Name Date