AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned below hereby authorizes Color Genomics, Inc. (“Color”) to disclose the below specified medical information to a designated recipient.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____

Date of Birth: _____

Patient’s Address: _____

Additional Verification Information (please provide any 1 of the following)**:**

- Last 4 digits of credit card associated with Color account_____
- Client ID (found under “account details” in Color online account)_____
- Ordering Provider (in Color online account, view results, click “more” and “view order details”)_____

I AUTHORIZE **COLOR** TO DISCLOSE TO:

NAME OF AUTHORIZED
RECIPIENT:_____

AT THE FOLLOWING ADDRESS: _____

ALL INFORMATION CONTAINED IN THE RECORDS SPECIFIED BELOW (INITIAL ALL APPLICABLE BOXES):

__[ ]__ ALL RECORDS regarding my treatment

__[ ]___ Test Request Form __[ ]___ Family History __[ ]___ Billing Records __[ ]___ Consultation Reports and Records __[ ]___ Laboratory Test Results __[ ]___ Raw Genetic Data

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Note: Color may charge you a reasonable fee for copying your records and providing them to you. In California, these fees are no more than $0.25 per photocopied page, and $0.50 per page for copies from microfilm. Any such reasonable fees will be documented on an invoice provided to you.

ALL SPECIMENS (IF AVAILABLE AFTER COMPLETION OF TESTING AND ANALYSIS) SPECIFIED BELOW (INITIAL ALL APPLICABLE BOXES):

__[ ]___ ALL REMAINING BIOLOGICAL SPECIMENS (if any) __[ ]___ Saliva sample (remaining portion, if any) __[ ]___ Blood sample (remaining portion, if any)

Note: If you have requested that your biological specimen be returned to you or delivered to a specified recipient, Color may charge you a reasonable fee for the shipment, handling, and packaging of such specimen. Any such reasonable fees will be documented on an invoice provided to you.

Method of delivery of requested records/information: ___Mail ___Pick up ___Electronic delivery, recipient email:_____ ___Telephone consult with Color Genetic Counselor, Clinical Pharmacist, or other Color support personnel

PURPOSE: The purpose and limitations (if any) of the requested use and

disclosure is:

_____

EXPIRATION: This authorization will expire after one (1) year.

MY RIGHTS:

• I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

• I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Color Genomics, Inc., Attn: General

Counsel, 831 Mitten Road, Suite #100, Burlingame, CA 94010. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

• I have the right to receive a copy of this authorization or inspect the information contained therein.

I understand that once the requested health information or sample is disclosed, any disclosure or use of the information or sample by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), or other applicable state and federal laws and regulations. I further understand and acknowledge that failure to provide *all* information requested many invalidate this authorization.

SIGNATURE*: _____ Date: _____

PATIENT OR LEGAL REPRESENTATIVE

PRINTED NAME:

_____

***If not signed by the patient, please indicate relationship to the patient (check one, if applicable):**

___Guardian or conservator of an incompetent patient. *Please include a copy of the conservatorship authorization.* ___Beneficiary or legal representative of deceased patient. *Please include a copy of the letter of executorship or letter of administration, or indicate beneficiary status here:* _____.