AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is to be used by a Color client, or legal representative thereof, to authorize Color Health, Inc. ("Color") to disclose protected health information to another individual or entity. Please type or print clearly and return as instructed. Each section needs to be completed to be a valid authorization request.

Color Client Information			
Client Name: (Last) (First) (Middle)			☐ Check this box if the client is deceased
Color Client ID # (optional)		Date of Birth (mm/dd/yy) / /	
Current Address	City	State	Zip
Phone Number ( )	Email Address (optional)		

Recipient Information			
Name of Individual or Healthcare Provider			
Address	City	State	Zip
Phone Number ( )	Fax Number ( )	Email Address	
Delivery Method (Select One): Mail Fax Email			

The purpose of this disclosure or use is:

- ☐ At Client's request
- ☐ Other (please specify): ____

Release the following information (check all applicable boxes):

- ☐ ALL RECORDS. This may include the test report, test requisition form, billing records, consultation report(s), and any other available health information.

OR

- ☐ Limited information and/or records (*check all that apply*)
  - ☐ Test Report
  - ☐ Test Requisition Form
  - ☐ Billing Records
  - ☐ Consultation Report(s)
  - ☐ Other: ________________________________

I, or my legal representative, understand and acknowledge that:

- I am voluntarily giving permission to Color to disclose my information to the recipient identified above. I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.
- This authorization will become effective immediately and shall remain in effect for one (1) year from the date of signature unless a different date is specified here _______________ .
- The authorization may be revoked at any time by providing a written notice of revocation to the following:

  Color Health, Inc.
  Attn: Legal
  831 Mitten Road, Suite 100
  Burlingame, CA 94010
  legal@color.com

  Revocation will be effective upon receipt except to the extent Color has already relied upon this authorization.
- I have the right to receive a copy of this authorization or inspect the information contained therein.
- Once the requested information is disclosed, any disclosure or use of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), or other applicable federal and state laws and regulations. Color will not be responsible for any redisclosure, whether or not permitted by law.
- Failure to provide *all* information requested may invalidate this authorization.
- I may be charged for copies in accordance with state law.

By signing below, I agree that I have reviewed and I understand this authorization:

Client Signature	Date

OR

Personal Representative Signature	Date
Print Personal Representative Name (please attach legal documentation)[1]	Relationship to Client

[1] If a personal representative is signing this authorization, a copy verifying the client's personal representative MUST accompany the request (e.g., court-appointed guardian, power of attorney for healthcare). However, if a parent is signing for a client under the age of 18, then no additional verification is necessary. For a deceased client, a copy of the death certificate must be provided along with additional documentation indicating that the personal representative is authorized to act on behalf of the deceased client, or the deceased client's estate.