MNG LABORATORIES
Neurogenetic Answers™

5424 Glenridge Drive NE
Atlanta, GA 30342 USA
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Authorization to Release Protected Health Information

CLIA License #11D0703390; CAP License #1441004; State of Georgia License #060-381

_____ _____
Parent Name (if 18 or older) or Parent/Legal Guardian *Phone Number (with area code)*

I am the (check one): ☐ Patient (must be 18 years of age or older) ☐ Parent ☐ Legal Guardian (Provide Proof)

_____ _____
Print Patient's Full Name *Patient's Date of Birth*

_____ _____
Authorized Signature *Date*

I HEREBY REQUEST AND AUTHORIZE:

MNG Laboratories
5424 Glenridge Drive NE
Atlanta, GA 30342
Phone: 678.225.0222
Fax: 678.225.0212

To release/discuss information from the medical records of the patient named above. I authorize release via telephone, secure fax, mail or secure email to:

_____
Facility Name / Other Authorized Person

_____
Physician Name

_____
Address *City* *State* *Zip Code*

_____ _____
Phone Number (include area code) *Fax*

_____
Secure Email

I HEREBY REQUEST AND AUTHORIZE (*please check all*):

☐ All information I hereby authorize to be obtained from this facility will be held in strict confidence. I place no limitations on history or illness (including HIV and/or AIDS) or diagnostic and therapeutic information, including any treatment of alcohol, drug abuse, or psychiatric disorders.

☐ I consent to the inspection of the above information by the above named agency/person and/or to the furnishing of a Photostat or other copies

☐ I understand that unless otherwise limited by the State or Federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. I also understand that this consent will not expire until the patient or his/her legal representative in writing withdraws it. The withdrawal of this authorization does not affect any health information disclosed prior to MNG Laboratories receiving written notice of withdrawal.

☐ I hereby release MNG Laboratories and its officers, directors, agents and employees from any and all liabilities, responsibilities, damages, losses and claims that might arise from the release of the information authorized above.

☐ I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily consent to the disclosure of this medical information to the individual or agency named above.

I HEREBY REQUEST AND AUTHORIZE THE TYPES OF RECORDS RELEASED (*please check all that apply*):

☐ Clinic Notes
☐ Consultation Notes
☐ Radiology Reports
☐ Doctor's Orders
☐ History & Physical Exam Report
☐ Operative Reports/Progress Notes
☐ Laboratory Reports
☐ Specimen Release
☐ All other related medical information