MOLECULAR PHOTOS

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (IMAGE)

Please read this entire form before signing and complete all sections of this form that apply to your decision relating to disclosure of protected health information. Covered entities as that term is defined by HIPAA and the Texas Health & Safety Code Section 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected heath information. Individuals cannot be denied treatment based on failure to sign this authorization form, and refusal to sign this form will not affect the payment, enrollments or eligibility of benefits.

Patient Name **Date of Birth**

(email a copy to hello@molcularphotos.com)

Address **Telephone Number** **Email Address**

I hereby authorize (name of facility/provider **releasing** information**) to disclose the above-named individual's health information:**

Name (facility releasing information) **Address** **City/State** **Zip** **Telephone**

Description of Information to be released: $50.00 will be paid to Pathologist / Group for services rendered (or donate payment to research).

_____ **Histology/Pathology Slide Images (Only to be uploaded to Molecular Photos Upload Site)**

This information may be disclosed to and used by the following individual or organization receiving the information, including via digital upload of the Information to www.molecularphotos.com:

Molecular Photos, Inc.
2204 Real Catorce Drive
Austin, Texas 78746
www.molecularphotos.com

Keep one copy for records

Reason for Disclosure: ☐ **Customized Histological Artwork ONLY***

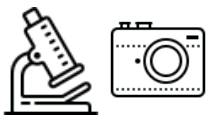
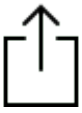
***If this request is for marketing purposes, the releasing facility may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's protected health information (PHI).**

I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that I may withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the releasing individual or organization. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. The releasing party may charge a processing fee for these services. This authorization is valid until the earlier of the occurrence of the death of the individual, or the following specific date (optional): Month_____ Day_____ Year_____

Signature Authorization: I have read this form and agree to the uses and disclosures of the information described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to written revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

_____ _____
Printed Name of Patient **Relationship to Patient (Example – Self)**

1	2	3	4	5	6
					
YOU Download form and complete	**YOU** Hand deliver, scan, or email completed form to Pathologist / group and hello@molecularphotos.com	**PATHOLOGY GROUP** Procure patient slide and capture high definition images, 40X and 100X	**PATHOLOGIST** Upload images to server with ID NUMBER to molecularphotos upload.com	**MOLECULAR** Once uploaded, Email conformation sent to patient with full invoice	**MOLECULAR** Customized Artwork sent within 12-15 business days

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