Patient Authorization Form

This authorization allows Caris MPI, Inc. d/b/a Caris Life Sciences ("Caris") to disclose and/or receive protected health information (PHI) for one or both of the following purposes listed below (select all that apply below). This form must be complete by you, your parent/legal guardian or legally authorized representative. Please email completed form to PatientNavigator@CarisLS.com or fax to 866-479-4925.

☐ **Insurance Appeal Representative Authorization:**

I hereby request and authorize Caris to represent me, and act on my behalf to my insurance payer ("Payer") regarding any appeals and/or denials issued for my claim for the services provided.

I authorize Payer to release any of my PHI to Caris and authorize Caris to release any of my PHI to Payer for the purpose of resolving my appeal. For purposes of this Insurance Appeal Representative Authorization, each of Payer and Caris shall each be considered a Disclosing Party and a Recipient of PHI.

My insurance Payer is: _____

☐ **Release of Protected Health Information Authorization:**

I hereby request and authorize Caris to release the following PHI: _____

to _____ (the "Recipient")

for the following purpose _____ .

I understand that I may revoke this authorization at any time, except to the extent that the Caris and/or Payer has taken action in reliance on the authorization. My revocation of this authorization will only be effective if I submit my revocation in writing to the Caris or Payer (if to Caris, then sent to: Caris Life Sciences, Legal Department, 750 West John Carpenter Freeway, Suite 800, Irving, TX 75039, USA; if to Payer, then to such address as Payer may designate).

I understand that I am not required to sign this authorization, and that my refusal to sign will not affect my eligibility for treatment, coverage or other benefits to which I am entitled from Caris and/or Payer.

I understand that information disclosed by Caris and/or Payer is subject to redisclosure by the Recipient and may no longer be protected by provisions of the Health Insurance Portability and Accountability Act, applicable state law or regulations.

This authorization will expire in two years from the date of signature unless a date or event is specified here:

_____

Caris and/or Payer may disclose my PHI pursuant to this request.

_____ _____

Signature of Patient or Patient's Representative *Print Name*

_____

Date

_____

Description of Representative's Authority to Act for Patient (if applicable)

_____

Caris MPI, Inc. d/b/a Caris Life Sciences ©2018 Caris Life Sciences. All rights reserved. TN0372 v2 June 15, 2018