Patient Authorization Form

Instructions: The patient or patient's personal representative must complete this 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 (select all that apply below):

☐ **Insurance Appeal Representative Authorization:**

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

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

My insurance Payor 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 Payor 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 Caris or Payor (if to Caris, send to: Caris Life Sciences, Legal Department, 6655 N. MacArthur Blvd, Irving, Texas 75039, USA; if to Payor, then to such address as Payor 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 Payor.

I understand that information disclosed by Caris and/or Payor 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 2 years from the date of signature unless a date or event is specified here:_______________

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

____ ____

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

________________________ ____

Patient Date of Birth *Date*

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

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