HIPAA Consent Form

Physician information			
Name:			Date:
National Provider ID:			
Email:		Phone Number:	
Account Information			
Practice/Hospital:			
Address:			
City:		State:	Zip:
Phone Number:			

Approved Person(s) to have access to Results Report and Web-Portal

Name:	Rep Group:	Phone Number:	Email:

Report : HIPAA Compliant PDXL LIM System Web Portal

By signing below, I authorize PersonalizeDx Labs to provide access to person(s) named above to view and access patient results and reports.

Print Name: Physician	
Signature:	DATE: