



Request for Restrictions

Patient Information:				
Patient Name			Myriad Patient ID #	
Current Address		City	State	Zip
Social Security Number - -	Phone Number ()		Date of Birth / /	

You have the right to request restrictions on the ways in which Myriad Genetic Laboratories, Inc. uses and discloses your health information. Myriad will carefully consider your request, but is not required to agree to it. If Myriad agrees to your request your information may still be shared during a medical emergency or as required by federal and state laws.

If you are requesting a restriction on disclosures to your health plan for services you have paid for out-of-pocket, the balance for those services must be paid in full at the time of your request; otherwise Myriad is not required to honor the restriction.

I am requesting the following restriction(s):
<input type="checkbox"/> Restriction on disclosure to person or entity (<i>name of person or entity</i>): _____ <input type="checkbox"/> Other (<i>please specify</i>): _____ <input type="checkbox"/> Restriction on disclosure to health plan related to services for which I paid in full out-of-pocket: (<i>specify type of service and date</i>): _____

If you checked "Other", Myriad will review your request and provide you with a written response. Depending upon the nature of your request it may take several days to respond. Until your request has been accepted, Myriad will use and disclose your health information in a manner consistent with our Notice of Privacy Practices and applicable law.

I understand that I or Myriad may terminate this restriction at anytime in the future. If Myriad decides to terminate an accepted restriction, I will be notified beforehand.

Patient or Personal Representative Signature	Date
Print Personal Representative Name (<i>please attach applicable legal documentation</i>)	Relationship to Patient

Please send this form to: Myriad Genetic Laboratories, Inc., Attn: Privacy Office, 320 Wakara Way, Salt Lake City, UT 84108

Date request received:	Reason for denial:
<input type="checkbox"/> Request accepted <input type="checkbox"/> Request denied	
Date notification sent to patient or personal representative:	<input type="checkbox"/> Restriction updated in applicable systems
Myriad representative name/signature	Date