



Request for Confidential Communications

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 how and where Myriad Genetic Laboratories, Inc. contacts you about your medical and billing information. We will accommodate reasonable requests if you provide a reasonable alternative means or location for communicating with you and let you know of our decision.

<i>Please check the information you are requesting to be changed:</i>	<i>New Contact Information to be Used:</i>
<input type="checkbox"/> Mailing Address	
<input type="checkbox"/> Billing/Guarantor Address, if different	
<input type="checkbox"/> Telephone	
<input type="checkbox"/> Other (<i>please specify</i>)	
Additional instructions:	

**Myriad does not routinely use email or fax to communicate with patients.*

If we accept your request, we will update our information systems with the information you have provided. Please note this request will not be communicated to anyone outside of Myriad, such as your insurance company or health care providers, and will not affect your communication preferences outside of Myriad.

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"/> Requested information updated in applicable systems
Myriad representative name/signature	Date

Shaded areas for Myriad use only