10X HEALTH

Cell Science Systems
Laboratory Name: Cell Science Systems
CLIA#: 10D0283906
FL Lic#: 800001500
852 S. Military Trail
Deerfield Beach, Fl 33442
(800) 872-5228 | cellsciencesystems.com

DNA Diagnostics Center
Laboratory Name: Clinical Enterprise
CLIA#: 22D1083041
MA Lic#: 5219
175 Crossing Blvd. Suite 400
Framingham, MA 01702
(877) 369-1056 | clinicalenterprise.com

American Screening Corp.
Laboratory Name: Plexus DX Inc.
CLIA#: 11D2214021
GA Lic#: 060-432
6110 McFarland Station Dr. Unit 604
Alpharetta, GA 30004
(470) 300-8838 | plexusdxlabs.com

Patient signature required to release results to health care provider

Medical Records Release

HEALTHCARE PROVIDER Clinic ID: 40997
Name: 10X Health Systems
Address: 2920 NE 207th St. #901, Miami, Fl 33180
Phone: (844) 977-2810 Acct. Exec. CF

I, the patient, (as listed in my patient account) hereby authorize Cell Science Systems, Corp, PlexusDX, Inc, or Clinical Enterprise, Inc, (collectively "laboratory vendors") and its affiliates, its employees and agents to release to the healthcare provider (as listed above) my PHI (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided by me and which identifies my name, date of birth, gender, address, and lab test results).

I understand that any PHI or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my signature on the previous page and this information shall be considered released to the stated party indefinitely unless a statement revoking this release is provided in writing in which the release of this information would end.

I understand that I have a right to revoke this authorization by providing written notice to Cell Science Systems, Corp, PlexusDX, Inc, or Clinical Enterprise, Inc. However, this authorization may not be revoked if the Laboratory Vendors, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my treatment, eligibility for benefits, enrollment, payment or coverage of services. A copy of this release will be considered as original with regard to the signature.

I, the patient, authorize the release of information, including a copy of digital test results, to the email address provided in my patient profile.

Specific provisions for the Privacy Act and Paperwork Reduction Act:
Cell Science Systems, Corp Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38, U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished completely and accurately, Cell Science Systems, Corp. will be unable to comply with the request. Cell Science Systems, Corp. may not condition treatment, payment, enrollment or eligibility on signing the authorization. Cell Science Systems, Corp. may disclose the information that you put on the form as permitted by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995.

PlexusDX, Inc Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38, U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished completely and accurately, PlexusDX, Inc. will be unable to comply with the request. PlexusDX, Inc. may not condition treatment, payment, enrollment or eligibility on signing the authorization. PlexusDX, Inc. may disclose the information that you put on the form as permitted by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995.

Clinical Enterprise, Inc Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38, U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished completely and accurately, Clinical Enterprise, Inc. will be unable to comply with the request. Clinical Enterprise, Inc. may not condition treatment, payment, enrollment or eligibility on signing the authorization. Clinical Enterprise, Inc. may disclose the information that you put on the form as permitted by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995.

Patient Name (Printed) : _____ Date : _____