**Exercise Your Rights Regarding Your Personal Information**

As mentioned in our Privacy Notices, various jurisdictions provide individuals with certain rights regarding the processing of their personal information.

To help you exercise your rights, we ask that you complete this form. Using this form will ensure that Agendia receives basic information about your request and the minimum personal information necessary to process your request. Agendia will carefully consider your request but may be denied under certain circumstances. We will contact you for additional information if the scope of your request is unclear or does not provide sufficient information for us to conduct a search. Agendia will not discriminate or retaliate against you for exercising your rights.

This form is not intended for access to medical information or medical records. If you are a patient and would like access to your test results, please contact our Customer Care department at customercare@agendia.com

**Complete and send this form to the Compliance Department**

Email: compliance@agendia.com, or Mailing address: Agendia, Inc, Attn: Compliance Department, 22 Morgan, Irvine, CA 92618, USA

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| **What Is Your Relationship To Agendia?** |
| [ ]  Job Applicant[ ]  Employee[ ]  Former Employee | [ ]  Patient[ ]  Agendia Website User[ ]  Recipient of Marketing Material | [ ]  Agendia Business Partner[ ]  Other:Click or tap here to enter text. |
| **Provide Information To Help Us Locate Your Records** |
| NameClick or tap here to enter text. | DOBClick or tap here to enter text. |
| AddressClick or tap here to enter text. | CityClick or tap here to enter text. | StateClick or tap here to enter text. | ZIPClick or tap here to enter text. |
| CountryClick or tap here to enter text. |
| Phone Number (optional)Click or tap here to enter text. | Email Address (optional)Click or tap here to enter text. | Last 4 of SSN (optional)Click or tap here to enter text. |
| **If You Are An Agendia Patient, Provide The Following Information?** |
| Name of Ordering Physician:Click or tap here to enter text. | Date of Service:Click or tap here to enter text. |
| Agendia Billing Account Number (if known):Click or tap here to enter text. | Medical Record Number (if known):Click or tap here to enter text. |

| **I Am Requesting The Following:** |
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| [ ]  **Request for Access to Personal information (select all that apply)** | [ ]  I am requesting a copy of Agendia’s privacy notice(s) that explains personal information collected about individuals and how it’s used.  |
| [ ]  I am requesting an Access Report regarding my personal information, contained by Agendia |
| [ ]  I am requesting a copy of my personal information, contained by Agendia. |
| Indicate how you would like to receive the information.Click or tap here to enter text. |
| [ ]  I am requesting a copy of my personal information, sent to another entity, on my behalf. |
| Please provide name of entity and method of deliveryClick or tap here to enter text. |
| [ ]  **Request an Accounting of Disclosure – USA patients only** | I am requesting information regarding disclosures of my protected health information |
| [ ]  **Request For Amendments/Corrections to Personal Information** | Please explain what the entry should say to be complete and accurate.Click or tap here to enter text. |
| Please explain why the entry is incomplete or incorrect.Click or tap here to enter text. |
| [ ]  **Request For Confidential Communications** | Indicate which information you are requesting to be changed.Click or tap here to enter text. |
| New contact information to be used.Click or tap here to enter text. |
| Additional instructionsClick or tap here to enter text. |
| [ ]  **Request Deletion of Personal Information** | Please describe the information you wish to be erased. Click or tap here to enter text. |
| Please supply us with the reason you wish your information to be erased.Click or tap here to enter text. |
| **Request for Restrictions/Objections Regarding the Use/Disclosure of Personal Information (select all that apply)** | [ ]  Restriction on disclosure to a person or entity (name of person or entity):Click or tap here to enter text. |
| [ ]  Restriction on disclosure to health plan related to services for which I paid in full: *(please specify the type of service and date of service)*Click or tap here to enter text. |
| [ ]  Object to processes that make decisions that impact me, and that are based solely on automated processing. Object to processing of my personal information by means of automated processing and that make decisions that impact me. Object to use of my personal information in decision making processes that are based solely on automated processing and that impact me. Click or tap here to enter text. |
| [ ]  Other *(please specify)*Click or tap here to enter text.*If “Other” is selected, Agendia will review your request and provide you with a written response. Depending upon the nature of your request it could take several days to receive a response. Until your request has been accepted, Agendia will use and disclose your personal information in a manner consistent with our Privacy Notice(s) and applicable law.* |
| **Opt Out Of Sale** | Agendia does not sale personal information, nor does it share personal information for cross-context behavioral advertising.  |

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| **Signature**  |
|  |  |  |  |  |  |
|  | Name (printed) |  | Signature |  | Date |
|  |
| If a person other than the owner of the personal information is submitting this request. provide the following: |
|  |  |  |  |  |  |
|  | Name (printed) |  | Signature |  | Date |
|  |  |  |
|  | Relationship to the Individual |  |  |
|  | * If you are a patient’s personal representative, provide a copy of legal paperwork, identifying you as such.
* If you are an “Authorized Agent” as defined by section §999.301(c) of the California Consumer Privacy Act, provide evidence of Individual’s signed permission to submit the request on their behalf.
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