TEMPUS

Every patient is unique.
Your treatment should be, too.

tempus.com/patients

Notice and Authorization for Health Records

Tempus is working to make precision medicine a reality for patients. And we need your help. Each person's medical circumstances are unique. Tempus has a database of de-identified health information from patients with different types of disease. We think we can improve medical care and research, in the United States and abroad, by adding more de-identified health information to our database.

By signing below, you give Tempus permission to access medical records from your health care providers. We will remove your name, date of birth, home address, e-mail address, and other identifying information from those records, following de-identification rules from a federal privacy law called HIPAA. We will store the resulting de-identified health information in our database.

We use our database of de-identified health information for many different purposes. We use it to improve our own internal laboratory operations. We share information from it with others, like universities, hospitals, and companies, who research the causes of disease, develop new therapies, and help pay for the cost of health care. We may receive payment when sharing the information. Your de-identified health information may be in some of the information that we use or share.

We follow the law when we use or disclose the information that we get from your authorization. **We will never use the information to market products or services to you. No one will contact you by phone or e-mail as a result of getting your information.** If you want to give us permission to access your medical records, please sign below.

Authorization for Provider to Release Health Information

I authorize all hospitals, physicians, medical practices, medical record departments, and other health care providers who have been or in the future will be involved in my health care (each a "Provider") to disclose my entire health record to Tempus Labs, Inc. I authorize each Provider to send my health record to Tempus, by e-mail at support@tempus.com, by mail to 600 W. Chicago Ave., Chicago, IL 60654, or by fax to (708) 575-1789.

This authorization is made at my own request, for the purposes described above. It will expire ten (10) years after the date of signature below. This authorization is for the health record that exists as of the date I sign this authorization. It also is for any new health records that may be created after the date I sign this authorization. This authorization does not permit disclosure of psychotherapy notes. If my health record includes genetic information or information related to communicable diseases (e.g. HIV or AIDS), behavioral/mental health, or substance abuse treatment, I permit this information to be disclosed to Tempus. If a Provider cannot release this type of information, then I authorize the Provider to release a copy of my health record with this information removed.

I understand that: 1) my health records may be re-disclosed by Tempus to other individuals or institutions and may no longer be protected by HIPAA; 2) I may refuse to sign this authorization; 3) my refusal to sign will not affect my ability to obtain treatment or benefits from Tempus or any Provider; 4) e-mail may be sent through unencrypted methods and I am aware of the possible risks of using unencrypted e-mail; and 5) I have the right to inspect and copy the information to be disclosed pursuant to this authorization and that I may obtain a copy of the information by contacting Tempus. I may take back ("revoke") this authorization in writing at any time by sending written notification to Tempus at its address listed above, to the attention of the Chief Privacy Officer. Tempus will then notify each applicable Provider in accordance with that Provider's usual practices for receiving revocations. I understand that any revocation will not apply to authorized uses or disclosures of my medical record that occurred prior to the date Tempus receives my written request to revoke authorization.

I HAVE READ AND UNDERSTOOD THIS FORM AND AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION.

Patient Signature: _____ **Email Address:** _____

Patient Name: _____ **Today's Date:** _____