VERACYTE PORTAL NEW USER SETUP FORM

PLEASE FAX THE COMPLETED FORM TO 650.243.6388

1 PRACTICE

PRIMARY PRACTICE NAME: ______________________________ *Required* **LOCATION (SITE NUMBER):** ______________ *Required*

PRACTICE 2: ______________________________ **LOCATION 2:** ______________

PRACTICE 3: ______________________________ **LOCATION 3:** ______________

PRACTICE 4: ______________________________ **LOCATION 4:** ______________

2 PHYSICIAN

By adding the physician name to the table below, you are authorizing Veracyte to upload his/her patient information to the Veracyte Portal, which can be accessed by all authorized personnel on this form.

- Indicate if the physician would like to receive an email notification when a report has been added to the Veracyte portal by selecting "self" under "Email Notifications Sent To"
- If the physician prefers to have email notifications sent to his/her staff, select "staff" and assign one (1) designated user to receive the email notifications
  - If "staff" is selected, list the admin name and email under section 3 below

PHYSICIAN NAME *Required*	PHYSICIAN EMAIL *Required for login*	EMAIL NOTIFICATIONS SENT TO *Required*
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________
		☐ SELF ☐ STAFF ☐ NONE Name: ______________

3 ADDITIONAL USERS

- List additional practice personnel and designated staff from section 2 above, who are authorized to access the Veracyte Portal

AUTHORIZED PERSONNEL NAME *Required*	EMAIL *Required*	TITLE

4 PHYSICIAN* SIGNATURE

I certify that the above individuals are authorized to access the Veracyte Portal.

PRINT NAME ____________________ DATE ____________________

SIGNATURE ____________________

HIPAA Warning: Failure to abide by federal HIPAA laws could lead to serious disciplinary sanctions which may include fines and civil or criminal prosecution. All users must comply with HIPAA privacy rule requirements while using this portal. Veracyte will not be held liable for any HIPAA violations resulting from your mis-use of the Veracyte Portal.

As new submitting or referring physicians are associated with your practice, their report delivery preference will be updated to include portal delivery of reports.

***Or authorized healthcare provider. A copy of this form shall be as valid as the original.**

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