Please send this form to:

NeoGenomics Laboratories, Attn: Compliance & Ethics Department, 9490 NeoGenomics Way, Fort Myers, FL 33912

Fax # 844) 890 - 9650;   compliance@neogenomics.com

Patient Information:				
Patient Name:		Patients ID / Account# (NEO Use):		
Address:	City:		State:	Zip Code:
Social Security Number: - -	Phone Number: ( )		Date of Birth: / /	

You have the right to request how and where NeoGenomics Laboratories, Inc. contacts you about your billing and medical information. We will accommodate reasonable requests if a reasonable alternative means or location for communication is provided. NeoGenomics will let you know once a decision has been made.

Please check the information you are requesting to be changed:	New Contact Information to be Used:
□ Mailing Address	
□ Billing/Guarantor Address, if different	
□ Telephone	
□ Other (please specify)	
Additional Instructions:	

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

If we accept your request, we will update the information in our systems with the information you have provided. Please note this request will not be communicated to anyone outside of NeoGenomics including your insurance company or health care providers. The above change will not affect your communication preferences outside of NeoGenomics.

Patient or Personal Representative Signature:	Date:
Print Patient/Personal Representative Name: (attach applicable legal documentation)	Relationship to Patient:

   PLEASE INCLUDE A COPY OF A GOVERNEMENT ISSUED ID (DRIVER'S LICENSE, ID CARD) FOR SIGNATURE VERIFICATION

FOR NEOGENOMICS ONLY:

Date Request Received:	Reason For Denial:
□ Request Accepted □ Request Denied	
Date Notification Sent To Patient Or Personal Representative:	□ Requested Information Updated In Applicable Systems

Reference: CORP-SOP-0214, CORP-SOP-0219, CORP-SOP-0220