R-F-CLT0517-02

PATIENT REQUEST FOR LAB RECORDS FORM

LABORATORY USE ONLY:

Site/Location where request submitted ________________Tech ID Releasing Records: ___________

Date of Records Release by Lab Staff: ________________ ☐LIS footnote completed if faxed

NAME OF PATIENT:____

Date of Birth: ________________

Indicate/circle the document used for identification:
(Driver's license, passport, military ID, other: ______________________________)

INFORMATION REQUESTED

Test reports for laboratory test(s) name or service date or Accn #: ________________________

METHOD OF DELIVERING INFORMATION:

______ I will pick up the records at ____

______ Please mail the records to me at ____

______ Please fax the records to me at (please include area code) ______________________

I understand that I am taking full responsibility for the accuracy and security of the mailing address or fax number to which I have requested the records be sent. This signed release is valid for 1 year.

____ ____________________
Signature: Date

IF YOU ARE NOT THE PATIENT: Health Information Management (HIM) must perform the release of patient records. If there will be repeated release of information to someone other than the patient, the lab may release the records after the first HIM approved release of information.

Name of Requestor: __________________________________ Date: ____________________

Indicate the document used for identification.
(Driver's license, passport, military ID, Other: ______________________________)