Patient Request to Access or to Disclose Protected Health Information (PHI)

In order for us to identify the requested patient PHI, please complete all required information. Using the information provided, we will attempt to identify the laboratory tests results and or order form.

Patient's Information			
Name: (Last)	(Middle)	(First)	
Phone Number:		**Date of Birth:**	
Address:			
Insurance:		**Insurance ID#:**	

Test Order Information		
Ordering Physician(s):		
Phone Number(s):		
Requested PHI:	☐ **Laboratory Test Results**	☐ **Order Form**

Requester Authorization			
Printed Name:			
Relationship to Patient (Check One):	☐**Self**	☐**Parent**	☐**Legal Guardian or Representative (Provide Proof)**
Signature:		**Date:**	

Delivery Instructions for Laboratory Test Results or Order Form:
Send to (Name):
Address (If different than above):
Fax Number:

Please fax the completed form (and any proof of representation, if required) to:
(973) 292-6290