19110_66th Ave. S., Bldg. G,
Kent, WA 98032
800.878.3787 **ph** 425.251.0596
fx 425.251.0637 / 425.656.2871

Authorization For Disclosure of Health Information

Patient(s) Name: _________________________ Accession #: ________________________

Patient(s) Date of Birth: ____/____/________

I hereby authorize the staff of Diagnos-Techs, Inc to release and discuss test results of the aforementioned patient with the following healthcare provider:

Print Name(s)/Organization: ____

Address: ____

____

Phone: ____

Fax: ____

Email: ____

Method of reporting: ( ) Mail ( ) Fax ( ) Email to: ____
I acknowledge that fax transmission or email delivery of these records may not be a confidential method and I will not hold Diagnos-Techs liable. (Initial here______)

For the Purpose of:

( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes ( ) Personal Interest

( ) Other (Specify)____

I acknowledge that Diagnos-Techs, Inc is not liable for the subsequent use of the related results. I understand that only licensed healthcare providers may contact Diagnos-Techs, Inc directly for an interpretation of test results received and that a copy of the provider's license must be faxed to 425-656-2871 prior to scheduling a consultation with them.

I hereby affirm that I have read and fully understand all of the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

____

Name (Please Print) Relationship to Patient

____

Authorized Signature Date