DiagnosTechs
CLINICAL & RESEARCH LABORATORY
THE LEADING LAB IN SALIVA TESTING SINCE 1989

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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