DiagnosTechs
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: ( ) 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 DiagnosTechs liable. (Initial here _____)

For the Purpose of:

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

( ) Other (Specify)_____

I acknowledge that DiagnosTechs, Inc is not liable for the subsequent use of the related results. I understand that only licensed healthcare providers may contact DiagnosTechs, Inc directly for an interpretation of test results received and that a copy of the provider's license must be received by DiagnosTechs prior to scheduling a consultation.

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