DiagnosTechs
CLINICAL & RESEARCH LABORATORY

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Authorization For Disclosure of Health Information

Patient Name: Accession #(s):

Patient Date of Birth (mm/dd/yyyy):

I hereby authorize the staff of DiagnosTechs, Inc to provide the following for the aforementioned patient:

Provide test results ☐

Provide Patient receipt ☐

Email result report(s) to:

I acknowledge that email delivery of these records may not be a confidential method and I will not hold DiagnosTechs liable. Initial here

Records are 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 if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I understand that only licensed healthcare providers may contact DiagnosTechs, Inc directly for an interpretation of test results received.

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