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: _____