Patient Request to Access or to Disclose Protected Health Information (PHI)

In order for us to identify the requested patient PHI, please complete all **required** information. Using the information provided, we will attempt to identify the laboratory tests results and or order form. *Indicates REQUIRED information.

A. Patient's Information:

Name*: _____ Phone Number: (_____) _____
First Name Middle Name/Initial Last Name

All other Names*: (nicknames, alternate spellings, former name, etc.):_____

Date of Birth*: _____
(MM/DD/YYYY)

Address*: _____

Social Security Number (last four digits)_____ Insurance ID# _____

B. Test Order Information:

Ordering Physicians' (or Office) Name(s)*: _____

Ordering Physician's Address(s)*: **Approximate Date(s) of Service*:** (MM/DD/YY)

_____ _____ _____

_____ _____ _____

Phone Number(s): (_____)_____ (_____)_____

Requested PHI: □ Laboratory Test Results □ Order Form

C. Requester Authorization:

By my signature, I request that DB Labs search its records and provide me or the individual I request in box D below, with a copy of the PHI requested. **NOTE**: If you are a legal representative of the patient please provide proof of representation as requested (healthcare proxy, court order, power of attorney, etc.).

Printed Name*: _____ ***Relationship:** (Check One)

☐ Self ☐ Parent ☐ Legal Guardian (Provide Proof) ☐ Legal Representative (Provide Proof)

Signature*: _____ **Date*:** _____

D. Delivery Instructions for Laboratory Test Results or Order Form:

Send to (Name)*: _____

Address (If different than above)*: _____
or
Fax Number*: _____

E. Please submit the completed form (and any proof of representation, if required) to:

DB Labs LLC
522 E Main St
Edmore, MI 48829

Or fax to: (989) 427-0364

DB Labs will respond within 30 days of receipt of this request.

Internal use only: Date received: _____

Initials: _____