REQUEST TO ACCESS

PROTECTED HEALTH INFORMATION (PHI)

NOT FOR DISCLOSURE TO ANYONE BUT THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE

Quest Diagnostics maintains separate records for each patient visit. The information provided on this request form will be used to search our records. To protect your privacy, we will release the protected health information (PHI) only when our records search results in a match with the information you provide on this form.

In response to this request, Quest Diagnostics will provide copies of test result report(s). This information is also available by contacting your physician and/or your insurance carrier.

Quest Diagnostics relies on information provided by the physician at the time the laboratory test is ordered. The information provided by the physician may not be sufficient to accurately match the information you provide on this Request form. In such cases, Quest Diagnostics will protect our patients' privacy by *not* releasing results that do not conform to our strict criteria for determining matches. Therefore, although the information you provide in this request will assist us to positively identify your records, there is no guarantee that all of your records will be identified. Failure to provide all information we request may prevent us from identifying some of your records.

PLEASE PRINT LEGIBLY:

Patient Name: _____

All other Names (nicknames, alternate spellings, maiden name, etc.) _____

Patient's Address at time of service

Street _____

City _____ **State** _____ **ZIP** _____

Social Security Number (or last four digits)_____
(Not required, but may help us to match records)

Insurance ID#_____
(Not required, but may help us to match records)

***Laboratory Information*:** Incomplete requests will be denied

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

Approximate Date(s) of Service (MM/DD/YYYY) _____

Type of Results Requested (Please Circle)**: Laboratory** (Quest Diagnostics) **Pathology/Biopsy (**Associated Pathologists, Chartered)

Authorization:
By signing below you request that Quest Diagnostics/Associated Pathologists, Chartered search its electronic records and provide you with a copy of the matching PHI maintained on this patient. In certain circumstances, a legal representative of the patient may request information on behalf of the patient. If you are the legal representative of the patient, please provide proof of representation (court order, power of attorney, etc.).

Printed Name _____ **Relationship to Patient:** (Check One)
Γ Self Γ Parent Γ Legal Guardian (Provide Proof) Γ Legal Representative (Provide Proof)

Signature:_____ **Date:**_____

Where would you like requests sent?: Γ **Mail to above addresses** Γ **Fax to**: (_____)_____

Γ **Send to alternative address**: _____

Quest Diagnostics generally will respond within 30 days of receipt of this request. Please submit this form (and any proof of representation, if required) to:
Mail to:
Quest Diagnostics, Nevada
Attn: Requests
4230 Burnham Ave
Las Vegas NV 89119

OR: FAX to: (702) 733-7650

OR: Drop off at any one of our PSC Locations

Internal use only:
Date Request Received: _____ Date Request Completed:_____

Employee Name pulling records: _____

Entered into PHI tracking database? Γ YES Γ NO