Patient's First Name: _____ Patient's Last Name:_____ DOB:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

1. I understand that this authorization will expire 1 year from the signature date
2. I understand that I may revoke this authorization prior to the release of results
3. I understand that I can refuse to sign and my service or care will not be affected
4. I may inspect or copy any information used or disclosed under this agreement
5. I authorize the release of medical information to other physicians and/or facilities involved in my health care.
6. I understand that if the person or organization that received the information is not a health care provider, the information described above may be redisclosed and would no longer be protected under these regulations.

I voluntarily authorize the disclosure of information from my health record to myself and other entities involved in my care.

×Signature:_____ **Date:**_____

……

You have the right to inspect and copy your own health care information, and that of an individual of whom you are a legal guardian or next of kin. Please provide the necessary information to access your lab results or simply decline this service below.

☐ I **DECLINE** access to my own lab results

OR

☐ **PORTAL ACCESS**: Please provide your e-mail address to receive a registration code to view all of your lab results online through our secure patient portal

E-MAIL:_____

☐ **MAIL RESULTS:** Receive results at your mailing address on file within 2 weeks of result completion.
This service costs $2.00 as the time of specimen collection

☐ I am next of kin requesting on behalf of the patient and our relationship is:

_____