

Patient Request for Laboratory Results

In order to assure patient identification in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Eurofins Diatherix Laboratories, LLC (EDL) requires the completion of the following information: *(All fields required. Please print legibly.)*

Patient name: _____	Patient date of birth: _____
Date test was collected: _____	
Name of ordering provider or office where test was collected: _____	
If you are not the patient then provide us with your name: _____	
Your relationship to the patient: _____	Phone #: _____
How would you like to receive your results (choose one): ☐ Via Email: If so, provide full email address: _____ <i>(Requestor accepts full responsibility of using an unsecured fax line.)</i> ☐ Via Fax: If so, provide fax number: (____) - ____ - ____ <i>(Emails will be encrypted)</i> ☐ Via US Mail: If so, provide mailing address: _____ _____ _____	
Note: <i>Explanation of results must be obtained from the ordering Provider.</i>	
I understand that this request is valid for the patient listed above and all results documented on this request will be released to the person signing this document. I understand EDL records will contain personal healthcare information and when released EDL is not liable for distribution beyond this signed request. If this document is not signed EDL will not be able to process the request and results will not be provided. By signing below, I hereby swear and affirm that the above statements are true and correct to the best of my knowledge.	
If parent, guardian or personal representative, print your name and relationship. Submit a copy of your healthcare or durable Power of Attorney. Name: _____ Relationship: _____	
Signature: _____ Patient Signature, Parent or Legal Representative	
Upon completion , return form by one of the following methods: • Fax to: 256.327.5259 • Email to: patientresults@eurofins-diatherix.com • Phone: 866.829.1854 • Hours: 8:00AM - 5:00AM (CST) Monday - Friday • Mail to: Eurofins Diatherix Billing Department, 601 Genome Way, Suite 2100, Huntsville, AL 35806	
If unable to fulfill this request, you will be notified by phone or by the result delivery method above. Please allow up to 15 days for EDL to reply to your request.	
For Eurofins Diatherix Staff Only: Received: ____ / ____ / ____ Completed: ____ / ____ / ____ Sent: ☐ Fax ☐ Mail Staff completing request _____	