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.

Request Date*: _____

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*:**

_____ _____ _____
_____ _____ _____

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

Requested PHI: □ Laboratory Test Results □ Order Form □ Other:_____

C. Requester Authorization:
I request that Quest Diagnostics search its records and provide me or the party named in box D below, with a copy of the PHI requested.

Check one of the following as applicable*:

☐ I am the patient named above.

or

☐ I am: ☐ Parent of patient
☐ Guardian of patient (Provide proof such as court order or power or attorney)
☐ Representative of patient (Provide proof such as court order, healthcare proxy, power of attorney)
Name (print): _____

D. Delivery Instructions for Laboratory Test Results or Order Form (check all that apply; please print)*:

☐ Patient at address above

☐ Patient at alternate address, or fax number or email address:_____

☐ Person(s) below

Name: Republic Services, Inc	Name: _____	Name: _____
Address: 2123 W. Governors Circle	Address: _____	Address: _____
Houston, Texas 77092	_____	_____
or	or	or
Fax Number: _____	Fax Number: _____	Fax Number: _____
or	or	or
Email address: _____	Email address: _____	Email address: _____

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

Quest Diagnostics
9601 Renner Blvd.
Lenexa, Kansas 66219
ATTN: Clinical Client Services

Or fax to: 1-855-854-9151
Or email to:
KCNOCRequesttoAccess@questdiagnostics.com

For easy electronic access to your lab results, please visit www.questdiagnostics.com/MyQuest or download the MyQuest App for iPhone or Android.

Quest Diagnostics will respond within 30 days of receipt of this request.

Internal use only: Date received: _____
Tracking #: _____ Initials: _____