Request to Access or to Disclose Patient 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 test results and or order form. *Indicates REQUIRED information.

A. Patient's Information:

Name*: _____ ____ _____ **Daytime Phone Number *:** (_____) _____
First Name **MI** **Last Name**

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

Date of Birth*: _____ **SSN# (last four digits)** _____ **Health Insurance ID#** _____

Address *: _____

B. Test Order Information:

Ordering Physician: _____

Ordering Physician Address: **Approximate Dates of Service: (Must be within 60 days from test date)**

_____ _____

_____ _____

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

Requested PHI: ☐ Laboratory Test Results ☐ Lab Order Form **(Check at least one)**

C. Requester Authorization:

By my signature, I request that SaraPath Diagnostics search its records and provide me or the individual I request in box D below, with a copy of the PHI requested. I understand that the electronic signature below shall have the same legal effect as if made under oath. I am aware that false information submitted in a document constitutes a third degree felony as provided in s. 817.155, Florida Statutes.

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.).

Relationship*: (check one) ☐ Self ☐ Parent ☐ Legal Guardian (Provide Proof) ☐ Legal Representative (Provide Proof)

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

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

Send to (Name)*: _____ **(check at least one box below)**

☐ **Mailing Address (if different than above):** _____ **or**

By checking "Fax" or "Email" below I understand that the requested information will be sent unencrypted, which could permit unauthorized parties to access my informantion.

☐ **Fax Number:** _____ **or**

☐ **Email address:** _____ **or**

I understand that I will be provided with a password that I will need to enter in order to be able to open and view my documents, and will need to provide a phone number to receive the password via an automated phone call or text message.

☐ **Secure Email address:** _____ **Email Verification Phone No.** (___)_____

E. Please submit by clicking the Submit button online at the bottom of the form, or by mailing or faxing the form to SaraPath as indicated below.

Mailing Address:
SaraPath Diagnostics
2001 Webber Street
Sarasota, FL 34239
ATTN: Client Services Center

Fax Number: 1-941-362-8911

Internal use only:

Date received: _____ *Tracking #:* _____ *Initials:* _____

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

Submit