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.

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*: (MM/DD/YY) ______________________

Phone Number(s): (____) ____________ (____) ____________

Requested PHI: ☐ Laboratory Test Results ☐ Order Form

C. Requester Authorization:

By my signature, I request that Quest Diagnostics search its records and provide me or the individual I request in box D below, with a copy of the PHI requested.
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.).

Printed Name*: ______________________ ***Relationship:** (Check One)
☐ Self ☐ Parent ☐ Legal Guardian (Provide Proof) ☐ Legal Representative (Provide Proof)

Signature*: ______________________ **Date*:** ____________

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: Records Deposition Service	Name:	Name:
Address: P.O. Box 5054	Address:	Address:
Southfield, MI 48086-5054		
or Fax Number: (248) 357-3337	or Fax Number:	or Fax Number:
or Email address: requests@recdep.com	or Email address:	or 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: 1-855-654-9151

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:* ________