



REQUEST FOR LABORATORY TEST RESULTS (PHI)

**Indicates REQUIRED information.*

A. Patient's Information

Name*: _____

[please print] First Name Middle Name/Initial Last Name

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

Date of Birth*: (mo) _____ (day) _____ (year) _____

Phone Number: (____) _____

Address*: _____

[please print] _____

Insurance Carrier, Address: _____

Insurance Policy/ID#: _____

B. Test Order Information

Ordering Physician's (or Office) Name(s)*: _____

Ordering Physician's Address(s)*: _____

Physician's Phone Number(s): (____) _____ (____) _____

Approximate Date(s) of Service*: (mo) _____ (day) _____ (year) _____

Requested PHI*[check box]: Laboratory Test Results Test Requisition Form Other PHI (to be specified) by the Requestor _____

C. Requester Authorization

By my signature, I request that Ridge Diagnostics search its records and provide me or the individual I request in section D below, with a copy of the laboratory test results (or other PHI) requested.

NOTE: If you are a legal representative of the patient, you must provide proof of representation as requested (healthcare proxy, court order, power of attorney, etc.).

Name [please print]*: _____

Relationship [check box]*: Self Parent Legal Guardian Personal Representative Designated Individual

Signature*: _____ Date*: _____

D. Delivery Instructions for Laboratory Test Results, Test Requisition or other PHI:

Send to*: _____

[please print] First Name Middle Name/Initial Last Name

By: U.S. Mail Address (if different than above)*: _____

or Fax Number*: (____) _____

or Email Email address [NOTE: file will be encrypted; password sent separately]*: _____

or Email, not encrypted [NOTE: email is not secure, and this is not recommended for Test Results, Test Requisition or other PHI]: _____

E. Please submit the completed form (and required proof of identity or representation) to:

Ridge Diagnostics Inc., ATTN: Client Services, 2 Davis Dr., PO Box 13169, Research Triangle Park, NC 27709
-or- Fax to Client Services 919-354-1048.

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

Internal use only Date/Initials, received: _____ SAL#: _____