Patient Request for Laboratory Results

Patient Name: ________________________________ **Patient Date of Birth:** _______________

Date of Physician Visit: _________________________

Name of Ordering Physician: ____

If you are not the patient then provide us with your name: _______________________________

Your relationship to the patient: ____

How would you like to receive your results (choose one):

☐ **Via Email?** If so, provide full email address: ____
(*Emails will be sent encrypted.*)

☐ **Via Fax?** If so, provide fax number: (______) - _______ - ___________
(*Requestor accepts full responsibility of using an unsecured fax line.*)

☐ **Via US Mail?** If so, provide mailing address: _______________________________________

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Note: *Explanation of results must be obtained from the ordering physician.*

Laboratory results cannot be given to patients without a signature on file. By signing below, I certify that I am the patient, parent, or personal representative of the individual named above. I understand that any falsification of my identity is prohibited and may subject me to penalties under federal and state law.

*If signee is a legal representative, please attach appropriate proof of representation such as Power of Attorney.

Signature: ____ **Date:** _______________
Patient Signature, Parent or Legal Representative*

Upon completion, return form by one of the following methods:

- Fax to: 256-327-0984
- Email to: clientservices@diatherix-eurofins.com
- Mail to: Diatherix Eurofins Client Services, 601 Genome Way, Suite 2100, Huntsville AL, 35806

If unable to fulfill this request, you will be notified by the result delivery method chosen above.

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