REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

For Internal Use:
Date Received _____
Tracking # _____
Initials _____

NOT FOR DISCLOSURE TO ANYONE BUT THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE

CompuNet Clinical Laboratories maintains separate records for each patient visit. The information provided on this request form will be used to search our records. To protect your privacy, we will release the protected health information (PHI) only when our records search results in a match with the information you provide on this form.

In response to this request, CompuNet Clinical Laboratories will provide copies of test result report(s). This information is also available by contacting your physician and/or your insurance carrier.

CompuNet Clinical Laboratories relies on information provided by the physician at the time the laboratory test is ordered. The information provided by the physician may not be sufficient to accurately match the information you provide on this Request form. In such cases, CompuNet Clinical Laboratories will protect our patients' privacy by *not* releasing results that do not conform to our strict criteria for determining matches. Therefore, although the information you provide in this request will assist us to positively identify your records, there is no guarantee that all of your records will be identified. Failure to provide all information we request may prevent us from identifying some of your records.

Patient's Information: (Incomplete requests may be denied)

Patient's Name _____ Phone Number (_____) _____ Daytime
First Name Middle Name Last Name (_____) _____ Evening

All other Names (nicknames, alternate spellings, maiden name, etc.)

_____

Patient's Address (This is the address where the response will be sent.)

Street _____

City _____ State _____ ZIP _____

Order Number: _____

Date of Birth _____
(MM/DD/YYYY)

Social Security Number (or last four digits) _____
(Not required, but may help us to match records)

Insurance ID# _____
(Not required, but may help us to match records)

Laboratory Information: : Complete this section for initial request only. For all subsequent requests in the same calendar year the patient will be required to provide ordering provider name, location of office & approximate date of service verbally when calling for results.

Ordering Physicians' (or Office) Name(s) _____ or **Phone Number(s)** (_____) _____
_____ (_____) _____
_____ (_____) _____

Address(es)
_____
_____
_____

Approximate Date(s) of Service (MM/DD/YYYY)
_____
_____
_____

Authorization: (**BOLD TYPE** Indicates Required Information. Incomplete requests will be denied.)
By signing below you request that CompuNet Clinical Laboratories search its electronic records and provide you with a copy of the matching PHI maintained on this patient. In certain circumstances, a legal representative of the patient may request information on behalf of the patient. If you are the legal representative of the patient, please provide proof of representation (court order, power of attorney, etc.).

Printed Name _____

Relationship: (Check One)
Γ Self Γ Parent Γ Legal Guardian (Provide Proof) Γ Legal Representative (Provide Proof)

Signature: _____ **Date:** _____

Alternate Patient Address:

Please send results to me at the following address: _____
OR FAX # _____

Contact Us: CompuNet Clinical Laboratories generally will respond within 30 days of receipt of this request. Please submit this form (and any proof of representation, if required) to:

CompuNet Clinical Laboratories
2308 Sandridge Dr.
Moraine, OH 45439

or FAX to: (Fax Number)
1-866-206-8387