BioReference LABORATORIES

PATIENT ACCESS REQUEST FOR LAB INFORMATION

Patient's Name: _____
(Last) (First) (Middle)

Date of Birth: ____/____/____ Preferred Tel. No.:___/_____/_____circle one: cell home business
Month/Day/Year

Address: _____
(Street) (City) (State) Zip Code)

Please provide: □ hard copy □ electronic format □ specific format: _____

Please request/check all that apply and include Lab ID # (if known) for each.

□ Lab Results_____ _____
□ Path Report(s): _____ _____
□ Other: _____
□ Entire Designated Record Set _____ □ Year _____

We will not condition testing or payment on whether you sign this authorization. However, if you refuse to sign we will not release your information.

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that BioReference Laboratories, Inc. (BRLI) provide me with access to health information in the manner described above. I understand that I will be contacted if BRLI can not produce the format I requested or if any fees will be charged for fulfilling this request. I will have an opportunity to modify or withdraw my request if I do not want to pay the fees specified.

Patient Signature _____ Date: _____
Personal Representative Signature: _____ Date: _____
Print Name: _____ Authority: _____
Address: _____ Tel No._____
(Personal Representative to sign only if patient is a minor or unable to sign on his/her own behalf.)
Need By: _____ Reason: _____

Send completed form to BioReference Laboratories, Inc., HIPAA Privacy Office, 481 Edward H. Ross Drive, Elmwood Park, NJ 07407 or Fax to: 201-791-1941

MR-2 (App 6/14) A

PSC USE ONLY!

☐ Government Issued ID Shown: