

## Instructions for Record Request Form

### 1. Patient Information:

Information is for the person for whom records are being requested. Name, address, date of birth and gender are required. Phone contact information and Insurance ID number will be helpful.

### 2. Medical Records Requested:

- Check the first box for results of lab tests collected or dropped off today.
- If older records are requested give as much detail as possible about the records. Indicate ordering physician name, city and state as well as month and year the tests were run.

### 3. Method of Transmission:

If the records are being sent to someone other than you, please enter the name of the person to receive the records.

The records can be sent to you in several different ways:

- Please indicate your preferred way to receive the records.
- Give the appropriate contact information for the format you choose.

### 4. Signature:

All requests must be signed and dated. If the person requesting the records is not the patient, please indicate what the relationship is between the requestor and the patient. Parents or legal guardians may obtain and/or authorize the release of protected health information from their child's medical record if the child is 17 years old or younger. Individuals over the age of 17 must authorize the release of their own information.

Legal Guardians and Personal Representatives must provide written documentation to prove the authority to access the records.

### 5. Identification:

This form can be left at the Clinical Pathology Laboratories (CPL) Patient Service Center. Please provide a valid picture identification to expedite the process.

Alternatively, the form may be mailed, emailed or faxed to CPL along with a copy of two forms of identification (Driver's license or State Identification card, Insurance card, Military ID, Social Security card, Passport, US Tribal or Bureau of Indian Affairs ID card, Certification of Citizenship – N560, Employee Authorization card). See bottom of form for submission information.

**NON-PORTAL RECORD REQUEST FORM**  
(instructions on reverse)

*Accession*

**1. PATIENT INFORMATION:**

*Name - Last	*First	MI	<b>82480</b>	
Other names to search (maiden name, nicknames, former names, etc)				
*Address				
Insurance I.D.		Cell Phone or Other Primary Phone		
*Date of Birth		*Sex		
MM - DD - YYYY		□		

**Patient Record Request**  
**9200 Wall Street**  
**Austin, TX 78754**

<i>Internal Use Only</i>	<input type="checkbox"/> Photo ID Verified	<b>RR 3</b>	<small>PSC ID</small>
<input type="checkbox"/> 810 Pt Record Request for current accession (place accession label above)	<input type="checkbox"/> 817 Standing/Future Order	<small>Rev 2022</small>	<small>Phleb ID</small>
<input type="checkbox"/> 815 Pt Records Request for past records			

**2. PLEASE INDICATE THE MEDICAL RECORDS REQUESTED:**

- Results for the laboratory tests collected or dropped off today (810)
- Prior results specified below (815)

Ordering Physician Name	Ordering Physician City & State	Date of Service Month & Year

Other records, specify records requested and approximate date of service (815) \_\_\_\_\_

**3. PLEASE SELECT ONE OF THE FOLLOWING METHODS FOR TRANSMISSION:**

Send to (enter Name if different from above): \_\_\_\_\_

\*By (please mark one):

- Email address: \_\_\_\_\_
- Fax Number: \_\_\_\_\_
- Mail (enter address if different from above): \_\_\_\_\_

My signature below authorizes Clinical Pathology Laboratories (CPL) to release the records containing Protected Healthcare Information (PHI) I have requested:

**4. \*Signature:** \_\_\_\_\_ **\*Date:** \_\_\_\_\_

\*Relationship:  Self  Parent  Legal Guardian (provide proof)  Personal Representative (provide proof)

\*Printed Name: \_\_\_\_\_ \*Initials: \_\_\_\_\_

**FOR INFORMATION OR TO SUBMIT FORM:**

Clinical Pathology Laboratories      phone: (844) 280-8484 (toll free)  
PO Box 144193                              fax: (844) 456-2264  
Austin, TX 78714-4193                    email: patientrecords@cpllabs.com

Visit: [www.cpllabs.com](http://www.cpllabs.com)

<b>Patient Verification of Information</b>
Initials _____
Date _____
For each use with 817

For patient safety, any changes to information require a new form to be completed.

\*Indicates REQUIRED Information