Patient Request to Access or to Disclose Protected Health Information (PHI)

In order for us to identify the requested patient PHI, please complete all **required** information. Using the information provided, we will attempt to identify the laboratory tests results and or order form. *Indicates REQUIRED information.

A. Patient's Information:

Name*: ______________________________ Phone Number: (____) ______________
First Name Middle Name/Initial Last Name

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

Date of Birth*: ______________________
(MM/DD/YYYY)

Address*: ______________________________

Social Security Number (last four digits)______________ Insurance ID# ______________

B. Test Order Information:

Ordering Physicians' (or Office) Name(s)*: ______________________________

Ordering Physician's Address(s)*: ______________________________

Approximate Date(s) of Service*: (MM/DD/YY) ______________ ______________

Phone Number(s): (____)______________ (____)______________

Requested PHI: ☐ Laboratory Test Results ☐ Order Form

C. Requester Authorization:

By my signature, I request that Top Notch Health search its records and provide me or the individual I request in box D below, with a copy of the PHI requested. NOTE: If you are a legal representative of the patient please provide proof of representation as requested (healthcare proxy, court order, power of attorney, etc.).

Printed Name*: ______________________________

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

Signature*: ______________________________ **Date*:** ______________

D. Delivery Instructions for Laboratory Test Results or Order Form:

Send to (Name)*: ______________________________

Address (If different than above)*: ______________________________
or
Fax Number*: ______________________________

E. Please submit the completed form (and any proof of representation, if required) to:

Or fax to: (989) 427-0364

Top notch health will respond within 30 days of receipt of this request.

Internal use only: Date received: ______________

Initials: ______