Diagnostic Solutions Laboratory

RESEARCH. TECHNOLOGY. RESULTS.

Patient Release of Medical Records to Self or Other

www.DiagnosticSolutionsLab.com
cs@DiagnosticSolutionsLab.com
877.485.5336
470.239.5017

Patient Release:

PLEASE PRINT. MUST BE PHYSICALLY SIGNED!

I, Patient/Guardian:_____ request and give my permission

the release of records for the time period dating from _____ to _____.

❑ Myself

❑ Other (PRINTED FULL NAME) : _____

Patient Information:

Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Ordering Physician/Clinic: _____ Fax: _____

Comments: _____

I would like my results to be sent via:

❑ Email (I UNDERSTAND DSL DOES NOT USE AN ENCRYPTED EMAIL) : _____

❑ Fax (ENTER FAX NUMBER) : _____

❑ Mailed by USPS (ENTER MAILING ADDRESS) : _____

❑ Other (PLEASE SPECIFY) : _____

Driver License or State Issued Photo ID:

A copy of a valid driver license or state issued ID must be included for DSL to release medical records.
Results will be sent within 30 days of request/availability.

Type of ID Presented:_____ ID#:_____

Printed Name of Patient/Guardian: _____ Date: _____

Patient/Guardian Signature (MUST BE PHYSICALLY SIGNED TO BE VALID) : _____

By signing this release form, I consent Diagnostic Solutions Laboratory to release my results as requested.

Email: cs@diagnosticsolutionslab.com | Customer Service: 877-485-5336 | Fax: 470-239-5017