LABTECH™
DIAGNOSTICS

PATIENT REQUEST FOR LABORATORY TEST RESULTS

LABTECH DIAGNOSTICS, LLC

1502 E Greenville St., Anderson, SC 29621 Phone: 864-760-0039 Fax: 864-760-0051

Patient Last Name: _____ Patient First Name: _____

Date of Birth: _____ / _____ / _____ Address: _____

Specimen Collection Date (if known): _____

Phone (Day): _____

Phone (Night): _____

Physician or Practice that initiated test: _____

I designate _____, receive my Laboratory Test Results, in my stead.

I request **Labtech Diagnostics, LLC** provide me, or my designee, named above, a copy of my Laboratory Test Results in the format and to the address, etc. below:

☐ **Unencrypted Email: _____**

☐ **Fax: _____**

I request **Labtech Diagnostics, LLC** provide a copy of my Test Results, and understand the law requires the laboratory to provide a copy of my Test Results to me within 30 days of the date of my request. As proof of identity, I have enclosed a copy of my driver's license, or other form of identification. I understand if I request my Test Results to be sent via email, that the email will not be encrypted and anyone with access to my email account (and potentially, those who don't), may be able to access my Test Results. I understand that these results are for clinical purposes only and should be reviewed by a physician

SIGNATURE: _____ DATE: _____ / _____ / _____

OFFICE USE ONLY:

Date Received: _____ / _____ / _____

Sent Via: _____ Date Sent: _____ / _____ / _____

Staff Member Name and Signature: _____