



PO Box 14346 | Research Triangle Park, NC 27709 | t 919-313-9672 | f 919-287-2476

## Request Form for Copy of Laboratory Report

Patient results can be mailed or faxed directly to the patient or an authorized patient representative. If you would like a copy of the final report, please complete the information below **AND** sign the bottom so we can authenticate your identity. This protects your HIPAA Privacy Rights. **Please note we are not able to provide results to you by e-mail.**

Patient Information	Please type or print legibly
First Name	
Last Name	
Date of Birth	
Address	
City, State	
Zip Code	
<b>SECURE</b> Fax Number	
Health Care Provider Information	Please type or print legibly
Provider Name	
Address	
City, State	
Zip Code	

**PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE SIGNATURE REQUIRED BELOW.** (Please provide driver's license and/or legal documentation for patient representative).

Printed Name	
Signature	
Date	

*Laboratories are required to provide a copy of the test results to you, but not to provide interpretation of test results. Please discuss your test results with your health care provider.*