CLINICAL LABS OF HAWAII

RECORD REQUEST FORM

1. Patient Information

Name (Last, First, M.I.)

Address

Label Here

Date of Birth | Gender M ☐ F ☐ X ☐ | Phone Number

2. Please Indicate the Medical Records Requested

☐ Results of the laboratory tests collected or dropped off today. (RFR)

☐ Historical results specified below. (RFRH)

Ordering Physician Name	Results Requested	Date of Service (Month & Year)

☐ Other records. Please specify records requested and approximate date(s) of service. (RFRH)

_____

_____

3. Please Select One of the Following Methods for Delivery

Send to (*enter Name if different from above*):_____

By (*please choose one from below*):

☐ Encrypted Email, please indicate address:_____

☐ Unencrypted Email, please indicate address:_____

NOTE: Unencrypted email is not a secure form of communication and there is some risk that individually identifiable health information or other sensitive or confidential information contained in such an email may be misdirected, disclosed to or intercepted by unauthorized third parties.

☐ Fax Number:_____

☐ Mail (*enter address if different from above*):_____

☐ Other (*specify*):_____

4. Authorization

My signature below authorizes Clinical Labs of Hawaii and Pan Pacific Pathologists to release the records containing Protected Healthcare Information as I have requested above:

Signature: **Date:**

_____ _____

Printed Name:

_____

Relationship: ☐Self ☐Parent ☐ Legal Guardian ☐Personal Representative ☐Patient Designee

Questions? Please call our Client Services at (808)677-7998

Internal Use Only: ___ Requestor's Identity Confirmed ___ Right to Access Confirmed

(Check all that apply) ___ Additional Authentication/Verification Required Tech ID:_____

Accessioners use Ordering Physician Number 834465 "Record Request"