Quest Diagnostics

NON-ORDERING TREATING HEALTH CARE PROVIDER REQUEST FOR LABORATORY REPORTS

To: Quest Diagnostics Incorporated

SPECIMEN NUMBER _____ (FOR LAB USE ONLY)

I am currently treating the patient identified below, and I am requesting the following laboratory test result(s) for that patient, which were ordered by another health care provider, be released to me solely for treatment purposes.

(Note to Non-Ordering Health Care Provider; Quest Diagnostics relies on Information provided by the ordering clinician at the time the laboratory test is ordered. The information provided by the ordering clinician may not be sufficient to accurately match the information you provide on this request form. In such cases, Quest Diagnostics will protect our patients' privacy by *not* releasing results that do not conform to our strict criteria for determining matches. Therefore, although the information you provide in this request may assist us to positively identify records, there is no guarantee that all records will be identified. Failure to provide all information we request below may prevent us from identifying some or all of the patient's records.)

TREATING HEALTH CARE PROVIDER (BOLD TYPE Indicates Required Information. Incomplete requests will be denied.) **REQUIRED**

Treating Provider's Name _____ _____ _____ **Phone Number** ( ) -
First Name Middle Name Last Name

Treating Provider's Address: (This is the address where the response will be sent.)

Quest Diagnostics Account # _____
OR

Street _____

UPIN # _____

City _____ **State** _____ **ZIP** _____

YOUR FAX NUMBER ( ) -

PATIENT'S INFORMATION (BOLD TYPE Indicates Required Information. Incomplete requests will be denied.) **REQUIRED**

Patient's Name _____ _____ _____ **Phone Number** ( ) - Daytime
First Name Middle Name Last Name

( ) - Evening

All other Names (Nicknames, alternate spellings, maiden name, etc.)

_____

Gender O **Male** O **Female**

Patient's Address:

Date Of Birth _____
(MM/DD/YYYY)

Street _____

Social Security # _____
(Not required, but may help us to match records)

City _____ **State** _____ **ZIP** _____

Insurance ID # _____
(Not required, but may help us to match records)

LABORATORY INFORMATION REQUESTED (BOLD TYPE Indicates Required Information. Incomplete requests will be denied.) **REQUIRED**

Date(s) of Service: _____ **Test(s) Performed:** _____

Ordering Physician's Name _____ _____ _____ **Phone Number** ( ) -
First Name Middle Name Last Name

Ordering Physician's Address:

Street _____

City _____ **State** _____ **ZIP** _____

TREATING PROVIDER'S SIGNATURE (BOLD TYPE Indicates Required Information. Incomplete requests will be denied.) **REQUIRED**

By signing below I request that Quest Diagnostics search its electronic records and provide me with copies of matching records maintained on the above referenced patient. An authorized designee of the treating provider may request information on behalf of the provider.

_____ _____
Signature **Date**

_____
Print Name and Title

RETURN COMPLETED FORMS BACK TO FAX NUMBER 818-776-9556 **ATTENTION:** _____