



## RELEASE OF LABORATORY RECORDS

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize Tesis Labs at 1408 Horizon Ave Suite 101, Lafayette, Colorado 80026, to disclose the following Protected Health Information pertaining to the above referenced patient to:

Name of Person or Entity: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please release the following results for:

\_\_\_\_\_ Lab Reports Date(s) of Service: \_\_\_\_\_

\_\_\_\_\_ Pathology Reports Date(s) of Service: \_\_\_\_\_

\_\_\_\_\_ Other (Please Specify): \_\_\_\_\_

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that receives the information.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship (if not patient) \_\_\_\_\_

Released by/Date \_\_\_\_\_