NTD Labs

REQUEST FOR HEALTHCARE RECORDS AND AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Instructions:

1. Please complete all fields. Any missing information may result in an invalid form or a delayed response. If you have any questions regarding this form, please contact: 1-888-NTD-LABS.
2. Photo copy the requestor's government issued photo ID. For a complete list of acceptable forms of identification, please visit our website at:
3. Send this form along with a copy of the requestor's approved photo ID to:

   Eurofins NTD, Inc.
   80 Ruland Road, Suite 1
   Melville, NY 11747
   Or Fax to 631-425-0864

Important Information: Test reports are not considered to be part of the healthcare record until the lab has completed its analysis of the specimen(s) and the results are finalized and ready for release.

RELEASE OF HEALTHCARE RECORDS		
☐ I AM REQUESTING LAB REPORTS ☐ I AM REQUESTING BILLING RECORDS ☐ I AM REQUESTING LAB REPORTS AND BILLING RECORDS		
For Date(s) of Service:		
PATIENT INFORMATION		
Name (Last Name, First Name MI):		
Date of birth:	**Sex:** ☐ Male ☐ Female	
Address:		
City:	**State:**	**ZIP Code:**
Ordering Physician's Name:	**Hospital/Practice Name:**	
REQUESTOR INFORMATION		
☐ Check here if you, the patient, are requesting your records. If you are the patient, you do not need to fill out the remaining portion of this section.	If you are NOT the patient, please explain your relationship to the patient:	
Name of Requestor (Last Name, First Name MI):		
Date of birth:	**Phone Number:**	
Please identify where the records should be sent:		
Address:		
City:	**State:**	**ZIP Code:**
PURPOSE OF RELEASE		
☐ Treatment/Continued Care	☐ Personal	☐ Legal Purposes
☐ Other:		

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REQUEST FOR HEALTHCARE RECORDS AND AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

AUTHORIZATION

I AUTHORIZE RELEASE OF THESE HEALTHCARE RECORDS TO:

☐ Myself

☐ Authorized Representative – person who has authority to act on behalf of the patient, e.g., power of attorney, legal guardian:

_ ____

☐ Other Designated Party: ____

If anyone other than the patient is requesting the above healthcare records, please indicate your legal authority and include documentation of your relationship (e.g., power of attorney, court order, birth certificate, notarized letter of designation, etc).

PATIENT'S RIGHTS

- I understand the records to be released may include records related to genetic material.
- I understand that I have a right to revoke this authorization at any time by notifying Eurofins NTD, Inc. Client Services in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this protected health information (PHI) is voluntary and I can refuse to sign this authorization. If I refuse to sign this authorization, Eurofins NTD, Inc. will not release any healthcare records pursuant to this request.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, and insurance company for eligibility, or a research project in which I am participating.
- I understand that I may be charged for copies and postage of the records in accordance with state law.
- The records subject to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- **This authorization expires ninety days after it is signed.**

SIGNATURE

I acknowledge that I am signing a legal document. I acknowledge that I understand and accept the terms on this form. I further certify that all the information I have provided in this form is true and correct to the best of my knowledge. I have signed this form freely and voluntarily.

Print Name (Patient/Authorized Representative): _ ____

Signature: ____**Date:** _ __________________

CONTACT INFO

Eurofins NTD, Inc. | www.ntdlabs.com | 1-888-NTD-LABS