UNIVERSITY SUBURBAN Health Center

LABORATORY DEPARTMENT
1611 SOUTTH GREEN RD, S EUCLID, OH 44121
216-382-9705

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

The USHC Lab (suite 016) maintains separate records for each patient visit. The information you provide on this request form will be used to search our records. To protect your privacy, we will provide you with copies of test results/records only when our search results in a match based on the information you provide below. You can also access tests results by contacting the practitioner who ordered your test(s).

USHC Lab relies on the information provided by your practitioner at the time the laboratory test was ordered, which may or may not be sufficient to accurately match the information you provide on this Request form. In such cases, the USHC Lab protects your 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 will help us positively identify your records, there is no guarantee that all your records will be identified. Failure to provide all the information we request may prevent us from identifying some of your records. USHC Lab records are available for up to two years prior to the request date. Older records are maintained in your physician's office(s).

Patient Information: **REQUIRED** (Incomplete requests will be denied.)

First Name: Last Name: Phone:

Alternate Names: Fax:
(nicknames, alternate spellings, maiden name, etc.)

Male: Female: Date of Birth: *Month* *Day* *Year* E-mail:

Address: City: State: Zip:

How would you like to receive your test results? (Please choose one.)

Fax results E-mail results: Mail results* Pick up results in suite 011. (Must bring photo ID)**

***Please provide a self-addressed stamped envelope at registration. Postage is available for purchase at the front desk.**
****If you don't pick up your lab results after 60 days, then the results (your protected health information) will be destroyed.**

Laboratory Information: **REQUIRED** (Incomplete requests will be denied.)

Ordering Physician's Name: Date(s) of Services: *Month* *Day* *Year*

Ordering Physician's Name: *Month* *Day* *Year*

Ordering Physician's Name: *Month* *Day* *Year*

Authorization: **REQUIRED** (Incomplete requests will be denied.)

By signing below you request that USHC lab staff search its electronic records and provide you with a copy of matching PHI maintained on the patient. In certain circumstances, the patient's legal representative may request information on behalf of the patient. If you are the patient's legal representative, please provide proof of representation (court order, power of attorney, etc.)

Signature: Self Parent Legal Guardian Legal Representative
(Please provide proof.)

Submit