GALAXYdiagnostics

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Request Form for Copy of Laboratory Report from Patient or Authorized Patient Representative

In order to provide a copy of the final laboratory results to you by mail, please complete the following information so that we can authenticate your identity. This protects your HIPAA Privacy Rights.

Patient Information	**Please type or print legibly**
First Name	
Last Name	
Date of Birth	
Address	
City, State	
Zip Code	
E-mail Address	
SECURE Fax Number	
Health Care Provider Information	**Please type or print legibly**
Provider Name	
Address	
City, State	
Zip Code	

Patient/Legal Patient Representative (please provide documentation if legal representative):

Printed Name	
Signature	
Date	

****Note that laboratories are required to provide a copy of the test results to you, but not to provide interpretation of test results. Please discuss your test results with your health care provider.***