Consent to Release Laboratory Test Results

Patient Name

Date of Birth

Recipient Name/Organization

Recipient Address / Email / Fax

Specific Laboratory Test Results to be Released

I hereby authorize the release of my laboratory test results as specified above to the indicated recipient.

- [ ] This authorization is valid for this instance only.
- [ ] This authorization is valid until revoked in writing.

Patient/Legal Representative Signature

Date

If signed by legal representative, specify relationship to patient