RELEASE OF LABORATORY RECORDS

Patient's Name:_____ Date of Birth: _____

I hereby authorize Tesis Labs 1140 Business Center Drive Suite 360, Houston, Texas 77043, 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