



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