REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

NOT FOR DISCLOSURE TO ANYONE BUT THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE
Under the HIPAA Privacy Rule, laboratories are not required to interpret / explain results to patients.

In order for us to identify the requested patient PHI, please complete all required information. Using the information provided, we will attempt to identify the laboratory tests results. *Indicates REQUIRED information

CDx Diagnostics, Inc. maintains separate records for each patient visit. The information provided on this request form will be used to search our records. To protect your privacy, we will release the protected health information (PHI) only when our records search results in a match with the information you provide on this form. In response to this request, CDx Diagnostics, Inc. will provide copies of test result report(s). This information is also available by contacting your physician and/or your insurance carrier.

CDx Diagnostics, Inc. relies on information provided by the physician at the time the laboratory test is ordered. The information provided by the physician may not be sufficient to accurately match the information you provide on this Request form. In such cases, CDx Diagnostics, Inc. will protect our patients' 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 assist us to positively identify your records, there is no guarantee that all of your records will be identified. Failure to provide all information we request may prevent us from identifying some of your records.

A. Patient's Information: (Incomplete requests may be denied)

Patient's Name*:_____ **Date of Birth*:**_____
First Name Middle Name Last Name (MM/DD/YYYY)

All other Names*: (nicknames, alternate spellings, maiden name, etc.): _____

Patient's Address*:
Street_____ **Phone Number** (_____) _____ Daytime
(_____) _____ Evening

City _____State _____ ZIP _____

Insurance ID# _____
(Not required, but may help us to match records)

B. Test Order information:

Ordering Physicians' (or Office) Name(s)*: or **Phone Number(s)*:** (_____) _____
_____ (_____) _____
_____ (_____) _____

Address(s)*: **Approximate Date(s) of Service*:** (MM/DD/YYYY)
_____ _____
_____ _____

C. Delivery Instructions for Laboratory Test Results:

Please review the information submitted in this section to ensure accuracy and completeness

Send results to (Name) * : _____

Address * : _____
(If different than above)
OR
Fax # * :_____

D. Requested Authorization:

By signing below, you request that CDx Diagnostics, Inc. search its electronic records and provide you with a copy of the matching PHI maintained on this patient. In certain circumstances, a legal representative of the patient may request information on behalf of the patient. If you are the legal representative of the patient, please provide proof of representation (court order, power of attorney, etc.). I have reviewed the information provided above in "Delivery Instructions" and certify that it is complete and accurate as entered.

Printed Name*:_____ ***Relationship**: (Check One)
☐Self ☐Parent ☐Legal Guardian ☐LegalRepresentative
(Provide Proof) (Provide Proof)

Signature *:_____ **Date*:** _____

E. Please submit the completed form (and any proof of representation, if required) to:

CDx Diagnostics, Inc.
Two Executive Boulevard
Suffern NY 10901

Or Fax to 845-368-7461

CDx Diagnostics, Inc. generally will respond within 30 days of receipt of this request.