Quest Diagnostics

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

For Internal Use:
Date Received _____
Tracking Number _____
Initials _____

Quest Diagnostics maintains separate records for each patient visit. The information provided on this request form will be used to search our records. To protect patient 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.

The PHI maintained by Quest Diagnostics is contained in two types of records—the test result report for medical information and the patient invoice for billing information. In response to this request, Quest Diagnostics will provide copies of the test result report(s) and/or patient invoice(s). This information is also available by contacting the patients' physician and/or patients' insurance carrier.

Quest Diagnostics 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, Quest Diagnostics 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.

Patient's Information: (**BOLD TYPE** Indicates Required Information. Incomplete requests will be denied.)

Patient's Name: ___ ___ _____ _____
First Name Middle Name Last Name

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

_____

►► Previous Address

Street _____

City _____ **State** _____ **Zip** _____

Street _____

City _____ **State** _____ **Zip** _____

►► Previous Phone Number (____) - _____ - _____
(____) _____ - _____

►► Gender ☐Male ☐ Female

Date of Birth: _____

►► Social Security Number: ___XXX-XX-____

(Not required, but may help us to match records).

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

Laboratory Information: (**BOLD TYPE** Indicates Required Information. Incomplete requests will be denied.)

►► Ordering Physicians' and/or (Office), Name(s) ___

_____

►► Address(es)

_____

_____

►► or Phone Number(s) (____) _____ - _____

Approximate Date(s) of Service (MM/DD/YYYY)

_____

ALL _____

Authorization: (**BOLD TYPE** Indicates Required Information. Incomplete requests will be denied.)
By signing below you request that Quest Diagnostics search its electronic records and provide **Unisource Discovery** with a copy of the matching PHI maintained on yourself. 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.).

Printed Name _____

Relationship: (Check One)
Γ Self Γ Parent Γ Legal Guardian (Provide Proof) Γ Legal Representative (Provide Proof)

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Signature

_____
Date

Contact Us:
Quest Diagnostics generally will respond within 30 days of receipt of this request. Please submit this form (and any proof of representation, if required) to:

Quest Diagnostics
3714 Northgate Boulevard
Sacramento, CA 95834
Fax: 916-286-8985

Please provide as much of the requested information as possible. This will help speed up the process. Thank you for your cooperation