PATHOLOGY CYTOLOGY LABORATORIES
290 BIG RUN ROAD
LEXINGTON KENTUCKY 40503
PHONE: 859-278-9513 TOLL FREE: 800-264-0514 FAX: 859-373-0254

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name:	Date of Birth:
SSN:	Address:
Phone:	City/State/Zip:

Form of Positive Identification Sent:

☐ Driver's License ☐ Student ID ☐ Other: ____________________

****Please send a copy of positive identifcation with the form when you return it to PCL.**

I hereby request that Pathology & Cytology Laboratories (PCL) release the medical records of:

____

To: ____

Records Requested: ☐ Reports ☐ Billing Statement ☐ Other: ____________________

For the Purpose of: ____

Date of Request: ____________________

Date Range Requested

From: ______________ To: ______________

Method of Delivery:

☐ Pickup ☐ Mail

☐ Fax: Number: ____________________

***At this time PCL does not offer medical records to be delivered in electronic format through email or on a portable drive.**
****If delivery is by fax, the requesting entity assumes responsibility for accuracy and security of number and location.**

Address for the records to be mailed to:

____

***PCL has 30 days to comply with all PHI requests. PCL will call requesting party when records are ready to be picked up.**

Signature: ____ Date: ____________________

Printed Name: ____

Relationship: ☐ Self ☐ Parent / Guardian ☐ Other: ____________________

Records Ready / Mailed / Faxed on: ____________________ Completed By: ____________________
*Please attach fax confirmation to this sheet for record keeping purposes.

Records Picked Up By: ________________________ Date: ____________________

**This form will remain in effect for 90 days from the date of signature, unless revoked in writing by the signer.

Created By: K.Howard 9/2014