YOSEMITE PATHOLOGY™
Quality diagnostics for optimum patient care

Patient Request to Access or to Disclose Protected Health Information (PHI)

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 and or order form. *Indicates REQUIRED information.

Request Date*: _____

A. Patient's Information:

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

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

Address*: _____

Phone Number: (_____)_____ **Social Security Number (last four digits)** _____

Insurance ID# _____

B. Test Order Information:

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

Case Number(s): _____ **Approximate Date(s) of Service*:** _____

_____ _____

Requested PHI:

☐ Laboratory Test Results ☐ Slide(s)/Block(s) ☐ Digital Slide Image ☐ Other: _____

C. Requester Authorization:

I request that Laboratory search its records and provide me or the party named in box D below, with a copy of the PHI requested.

Check one of the following as applicable*:

☐ I am the patient named above.

or

I am: ☐ Parent of patient
☐ Guardian of patient (Provide proof such as court order or power or attorney)
☐ Representative of patient (Provide proof such as court order, healthcare proxy, power of attorney)

Name (print): _____

D. Delivery Instructions for Laboratory Test Results or Order Form (check all that apply; please print)*:

☐ In person pick-up at: 4301 Northstar Way, Modesto, CA 95356
☐ Patient at address above
☐ Patient at alternate address, or fax number or email address:_____
☐ Person(s) below

Name: _____	Name: _____	Name: _____
Address:_____	Address:_____	Address:_____
_____	_____	_____
or	or	or
Fax Number;_____	Fax Number:_____	Fax Number:_____
or	or	or
Email address: _____	Email address: _____	Email address: _____

E. Purpose of Disclosure:

The purpose of this release/disclosure to another person/organization is the following:

□ Continuation of Care/Transfer of Care	□ Attorney/Legal
□ Insurance Company	□ Workman's Compensation
□ Other (Specify):	

NOTICES

- The laboratory and your treating physician are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

- Appropriate medical expertise is required for the correct interpretation of clinical laboratory results. Under no circumstances should you take any action based on laboratory test results without first communicating with your physician/practitioner.

- Please note that while most requests for the release of PHI are processed immediately upon receipt in their respective department, under California state law, the Laboratory has 15 days in which to fulfill each request. Furthermore, some requests may require additional processing time in addition to the initial 15 days. If applicable, you will be notified.

INSTRUCTIONS

Once you have filled out this form in its entirety or to the best of your knowledge, email it along with **two forms of ID** to secretaries@ypmg.com. A driver's license or state ID as a primary document is acceptable, along with a health insurance card or utility bill as a secondary document disclosing patient's full name.

MY RIGHTS

- This authorization to release health information is voluntary. You make may revoke this authorization at any time. The revocation must be in writing, signed by you or your legal representative and delivered to the laboratory and will take effect when the laboratory receives it, except to the extent the Laboratory has already relied on the authorization and disseminated your PHI to anyone designated by you in the original authorization.

- Unless otherwise revoked, this authorization expires _____ (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

CONSENT

I hereby request Laboratory release copies of my laboratory results.

Signature of Patient or Legal Guardian (if minor): _____ Date: _____.

Signature of Personal Representative: _____ Date: _____

For Office Use Only:				
Information:	□ Mailed	□ E-Mailed	□ Picked Up	□ Faxed
ID Verified:	□ Yes	□ No	Two (2) Types of Verification:	
Date Received:			Date Processed:	
Processed By:				