EAST SIDE CLINICAL LABORATORY
A Sonic Healthcare Company

RECORD REQUEST FORM

(Instructions on reverse)

1. PATIENT INFORMATION: (PLEASE PRINT)

*Name - Last *First MI

Other names to search (maiden name, nicknames, former names, etc)

*Address

Insurance I.D. Cell Phone or Other Primary Phone

*Date of Birth MM DD YY *Sex

Internal Use Only

☐ Picture ID verified by _____ (initials)

2. Request for reports specified below:

Ordering Physician Name	Ordering Physician City & State	Date of Service Month & Year

3. PLEASE SELECT ONE OF THE FOLLOWING METHODS FOR TRANSMISSION:

*Send to *(enter Name if different from above)*: _____

*By *(please mark one)*:

- ○ Email address: _____
- ○ Fax Number: _____
- ○ Mail *(enter address if different from above)* : _____
- ○ Pick up at PSC *(specify location)*: _____
- ○ Patient Portal (Personal Account)
- ○ Patient Portal (Guardian Account)

My signature below authorizes East Side Clinical Laboratories (ESCL) to release the records containing Protected Healthcare Information (PHI) I have requested.

4. *Signature: ***Date:**

(provide proof) (provide proof)

***Printed Name:** ***Relationship**: ○ Self ○ Parent ○ Legal Guardian ○ Personal Representative

***Initials** _____

FOR INFORMATION OR TO SUBMIT FORM:

Client Services Department
East Side Clinical Laboratories
10 Risho Ave
East Providence, RI 02914

phone: (401) 455-8400
fax: (401) 434-3928

ESCL will use best efforts to respond within 2 weeks of request unless testing requires extended period of time.

For patient safety, any changes to information requires a new form to be completed.

*Indicates REQUIRED Information

Instructions for Record Request Form

1. Patient Information:

Information is for the person whose records are being requested. Name, address, date of birth and gender are required. Phone contact information and Insurance ID number will be helpful.

2. Medical Records Requested

Give as much detail as possible about the records being requested. Indicate ordering physician name, city and state as well as month and year the tests were run.

3. Method of Transmission

If the records are being sent to someone other than you, please enter the name of the person to receive the records.

The records can be sent to you in several different ways:

- Please indicate your preferred way to receive the records.
- Give the appropriate address for the format you choose.

4. Signature

All requests must be signed and dated. If the person requesting the records is not the patient, please indicate what the relationship is between the requestor and the patient. Legal Guardians and Personal Representatives must provide written documentation to prove the authority to access the records.

This form can be taken to an East Side Clinical Laboratory (ESCL) Patient Service Center. Please provide a valid picture identification to expedite the process.

Alternatively, the form may be mailed, emailed or faxed to ESCL along with a copy of two forms of identification (Driver's license or State Identification card, Insurance card, Military ID, Social Security card, Passport, US Tribal or Bureau of Indian Affairs ID card, Certification of Citizenship – N560, Employee Authorization card). See bottom of form for submission information.