EAST SIDE CLINICAL LABORATORY
A Sonic Healthcare Clinical Laboratory

Information for patients

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.

RECORD REQUEST FORM *Indicates REQUIRED Information

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 *Biological Sex

☐ Female ☐ Male

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 the Following Method 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)*: _____

4. *Signature *Date

(Provide Proof)

***Printed Name:**

***Relationship:** ☐ Self ☐ Parent ☐ Legal Guardian ☐ Personal Representative

For Information, or to submit form:

East Side Clinical Laboratories

10 Risho Ave, East Providence, RI 02914 | **Client Services Department Phone:** 401.455.8400 | **Fax:** 401.400.7044

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.

EAST SIDE CLINICAL LABORATORY

East Side Clinical Laboratories
10 Risho Avenue
East Providence, RI 02914

www.eastsidelab.com
P: 401.455.8400