STONE CLINICAL LABORATORIES **PROTECTED HEALTH INFORMATION REQUEST**

All sections of the form must be completed in order for Stone Clinical Laboratories to fulfill the request.

REQUESTED PHI ☐ LABORATORY TEST RESULTS ☐ ORDER FORM ☐ OTHER: _____ ☐ TOX ☐ BLOOD ☐ PGX

I, _____, request that Stone Clinical Laboratories provide a copy of the item selected above for the specimen sent on _____ to Stone Clinical Laboratories for testing. I understand that Stone Clinical Laboratories will not provide interpretation of results, of the testing that has been ordered.

Please complete the section below ***ONLY*** *if you are the patient's designated representative*

I _____, the personal representative, for _____ (patient name) have the authority under applicable law to make health care decisions for the individual listed above. I have provided copies of the following documents along with this request to support that authority (health care proxy, court order, power of attorney etc.).

By my signature, I request that Stone Clinical Laboratories search its records and provide me or the individual I request in the "Delivery Instructions" box below, with a copy of the PHI requested.

NOTE: If you are a legal representative of the patient please provide proof of representation as requested (healthcare proxy, court order, power of attorney, etc.).

_____ RELATIONSHIP (CHECK ONE): ☐ SELF ☐ PARENT ☐ LEGAL GUARDIAN* ☐ LEGAL REPRESENTATIVE*
PRINTED NAME

_____ _____
SIGNATURE DATE *DOCUMENTATION WILL BE REQUIRED

PATIENT INFORMATION

_____ _____ _____
FULL NAME PHONE NUMBER DATE OF BIRTH

_____ _____
ADDRESS CITY

_____ _____ _____ _____
STATE ZIP CODE INSURANCE ID # DATE OF SERVICE

TEST ORDER INFORMATION

_____ _____
ORDERING PROVIDER NAME FACILITY/PRACTICE NAME

_____
ORDERING PROVIDER ADDRESS CITY STATE ZIP CODE

_____ _____
ORDERING PROVIDER PHONE NUMBER STONE ACCOUNT NUMBER

DELIVERY INSTRUCTIONS FOR LABORATORY TEST RESULTS OR ORDER FORM

_____ _____
SEND TO (NAME) FAX NUMBER

_____
ADDRESS (IF DIFFERENT THAN ABOVE) CITY STATE ZIP CODE

Please submit the completed form (and any proof of representation, if required) to:

Stone Clinical Laboratories
615 Baronne Street, Ste 100
New Orleans, LA 70113
ATTN: Client Services
or fax to: 504.910.9624

Internal use only:

Date received: _____ Tracking #: _____

Date sent: _____ Initials: _____

Account #: _____

Stone Clinical Laboratories will respond within 30 days of receipt of this request.

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