

# Patient Request for Health Information

**Patient Information (Please Print)**

First Name:		Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):				
Date of Birth (MM/DD/YYYY):		Phone:	E-mail (optional):	
Street Address:		City:	State:	Zip:

**What records do you want? (Check appropriate boxes below):**

Date(s) of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

- All laboratory test results:  
 Individual tests: Please specify: \_\_\_\_\_  
 Other: Please specify: \_\_\_\_\_

**How would you like your records delivered?**

- Paper  
 In-Person Pickup  
 Electronic/Email  
 Fax

**Where do you want the information sent? (Fill in boxes below):**

[Infiniti Labs](#) should provide my records to:  Self  Personal Representative (indicated below)

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:
	Recipient E-mail (if applicable):

**Please print your name and sign below** *\*Your signature indicates you are accepting your own laboratory results. Infiniti Labs strongly encourages you to discuss your results with your healthcare provider before acting on any clinical findings\**

<b>Name of Patient or Personal Representative (please print)</b>	<b>Relationship (please print)</b>
<b>Signature of Patient or Personal Representative</b>	<b>Date/Time</b>

**Please return completed form to:**

<a href="#">Infiniti Labs</a> 6015 Benjamin Rd, Suite 315 Tampa, Florida 33634	Fax: 813-886-2735
	Questions?

INFINITI LABS recognizes a patient's right under HIPAA to access copies of his/her health information.

There may be charges associated with processing a request and producing requested records.