



FORM MUST BE SUBMITTED ALONG WITH FRONT AND BACK COPY OF DRIVERS LICENSE

1: PATIENT INFORMATION:

*Name -Last _____ *First _____ MI _____

Other names to search (maiden name, nickname, former names, etc) _____

Address _____ City _____ State _____ ZIP _____

Cell Phone or Other Primary Phone _____ *Date of Birth - - *Sex

2. PLEASE INDICATE THE MEDICAL RECORDS REQUESTED:

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

Other records, specify records requested and approximate date of service _____

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): _____

My signature below authorizes Sonic Healthcare USA Anatomic Pathology to release the records containing Protected Healthcare Information (PHI) I have requested:

4. * Signature

*** Date**

*Relationship: Self Parent (provide proof) Legal Gaurdian (provide proof) Personal Representative (provide proof)

*Printed Name: _____ *Initials: _____

PLEASE SUBMIT COMPLETED FORM AND FRONT AND BACK COPY OF DRIVERS LICENSE:

Fax: 904.512.6188
Email: BhlCustomerService@sonichealthcareusa.com
For assistance, please call 800.766.7718 or 904.296.2333

Patient Verification of Information	
Initials	_____
Date	_____

For patient safety, any changes to information require a new form to be completed.
*Indicates REQUIRED Information