Release of Medical Information

To request release of medical information, please complete and sign this form and return it to:

Laboratory Records Department
Trace Elements
4501 Sunbelt Drive
Addison, Texas 75001

You may also submit this form by Fax to:
972-248-4896 or you may scan and send via e-mail to: teilab@traceelements.com

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Telephone: _____

(Health Professional currently on record)

Name: _____ Degree(s): _____ TEI Account #: _____

Trace Elements has my permission to release or disclose the following Protected Health Information (PHI)* for the above named patient.

* Copies of any and all records, laboratory reports, or any other information concerning medical history, diagnosis, recommended treatment and prognosis.

Trace Elements will make available for release or disclosure the information requested above to the following Designated Party:

Last Name: _____ First Name: _____ Degree(s): _____

Street Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-Mail: _____

TEI Account # (if applicable): _____

In the event that Trace Elements is requested to provide printed reports or documentation, I understand and accept that there may be a charge for any resending of previous laboratory reports and duplication of records at the rate of $ 8.00 per report or record, and payment will be due at time of request. Printing and/or duplication of records will be processed within thirty (30) days of receipt of authorization and payment.

I authorize the use of fax or scanned/e-mail attachment for the release or disclosure of the information described above.

I understand and accept the above request for release and disclosure of personal medical information in its entirety. I further understand that I can cancel this release in writing at any time.

_____ _____

Signature of Patient (if 18 years of age or older) **Date**

_____ _____ _____

Signature of Parent or Guardian (if minor patient) **Relationship to Patient** **Date**