Patient Request for Health Information

APEX LABS
Clinical Laboratory
6015 Benjamin Road, Suite 315 • Tampa, FL 33634
813-886-2616 • www.Apex-Labs.net

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):

Apex Labs should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

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

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

Name of Patient or Personal Representative (please print)	**Relationship (please print)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form to:

Apex Labs 6015 Benjamin Rd, Suite 315 Tampa, Florida 33634	**Fax**: 813-886-2106
	Questions?

APEX 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.