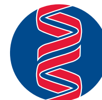
Patient Record Request Form

Request #________________________________



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1. Patient Information

*Name: *Last:________________________ *First:________________________ M.I.:______

Other names to search (maiden name, nicknames, former names, etc.):________________________

*Address:________________________

Insurance I.D.:______________ Insurance Billing Statement #:______________ Cell Phone or Other Primary Phone #:______________

*Date of Birth:______________ *Gender:______________ Social Security # (Last 4 Digits):______________

Internal Use Only: ☐ Patient Record Request for test results ☐ Patient Record Request for other documents
☐ Photo ID Verified ☐ Proof of Parental Relationship ☐ Proof of Representation

2. Please Indicate the Medical Records Requested: ☐ Results for laboratory tests

☐ Other records (specify records requested and approximate date of service):________________________

*Test Requested:______________ *Ordering Physician's Name:______________ *Ordering Physician City & State:______________ *Date of Service:______________	*Test Requested:______________ *Ordering Physician's Name:______________ *Ordering Physician City & State:______________ *Date of Service:______________
*Test Requested:______________ *Ordering Physician's Name:______________ *Ordering Physician City & State:______________ *Date of Service:______________	*Test Requested:______________ *Ordering Physician's Name:______________ *Ordering Physician City & State:______________ *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): ☐ Mail (enter address if different from above):________________________

☐ E-mail:________________________

☐ Fax:________________________

☐ In Person at: ☐ 760 Westchester Ave, Rye Brook, NY

☐ Other (specify):________________________

Signature My signature below authorizes CBLPath to release the records containing Protected Healthcare Information (PHI) I have requested.

*Signature:________________________ *Date:______________

*Printed Name:________________________

*Relationship: ☐ Self ☐ Parent ☐ Spouse ☐ Personal Representative ☐ Legal Guardian

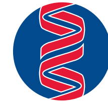
For Information or to Submit Form:

Mail to CBLPath, Inc., Attention: Customer/Patient Services, 760 Westchester Av, Rye Brook, NY 10573

Phone: 877.225.7284 (toll free) Fax: 866.329.2252 E-mail: ClientServices@cblpath.com

CBLPath will use best efforts to respond within 10 days of this request once all requirements have been met unless record set access requires an extended period of time. For security purposes, any change to information requires a new form to be completed.

***Indicates Required Information**



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Instructions for Record Request Form

Please Legibly Complete Sections 1-4

1. Patient Information

Information is for the person whose records are being requested. Completely and legibly fill out the patient's name, address, date of birth and gender, which are all required. Phone, social security, and insurance ID numbers will help expedite the process.

2. Medical Records Requested

Check the first box for laboratory test results and the second for other documents. If older records are requested, give as much detail as possible about the records. Indicate the test requested (i.e. breast biopsy), ordering physician's name, ordering physician's city and state and the date of service.

3. Method of Transmission

If the records are being sent to someone other than you, please enter the name of the person you would like to receive the records. The records can be sent to you in several different ways. Check the method in which you would like it sent:

- Please indicate your preferred method of receiving the records.
- Please give the appropriate address for the format you choose.

4. Signature

All requests must be signed and dated. If the person requesting the records is not the patient, please indicate what the relationship is between the requestor and the patient. Legal guardians and personal representatives must provide written documentation to prove the authority to access the records.

Alternatively, the form may be mailed, e-mailed, or faxed to CBLPath, along with a copy of two forms of identification (Driver's License or State Identification card, Insurance card, Military ID, Social Security card, Passport, US Tribal or Bureau of Indian Affairs ID card, Certification of Citizenship – N560, or Employee Authorization card) and verification of representation. See bottom of form for submission information.

If you have any questions, please contact CBLPath Client/Patient Services at 877.225.7284.