



Medical Records Release Form

Allele Diagnostics
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Phone: 844-ALLELE2 (255-3532)
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Allele Diagnostics understands that records may need to be provided to healthcare providers other than the clinician that ordered the original testing. We require that this form be completed by a healthcare provider caring for the patient for us to release records. If desired, the health care provider can contact our laboratory at 844-ALLELE2 (255-3532) to discuss their request in more detail prior to completing and submitting this form. Once the form has been received in the laboratory, it may take up to 30 days for records to be transmitted. NOTE: If the records release is being requested by the patient or legal guardian, a separate authorization must be completed. For the Patient/Legal Guardian Request For Records Form, please contact the laboratory.

Sample Information	
Patient Full Name: _____	Patient Date of Birth: _____
Records Requested: _____	
Date request expires (if not specified, request will no longer be valid 3 months from date request is received in laboratory): _____	
Clinician Contact Information	
The records will be provided to the clinician at the contact information listed below.	
Laboratory / Institution Name: _____	
Physician/Healthcare Provider Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Country (if outside of US): _____	
Telephone: _____	Fax: _____
Email (required if outside of US): _____	
Authorized Signature(s) for Release of Records	
Health Care Provider Name (First, MI, Last): _____	
NPI#: _____	
Authorized Health Care Provider: As an authorized health care provider, I request and authorize Allele Diagnostics to release the records listed above to the fax number and/or address listed above. By signing below, I verify that I am an authorized health care provider and have obtained consent from the patient(s) and/or legal guardian(s) for the release of specimens.	
Signature: _____	Date: _____
<i>Signature of Authorized Health Care Provider</i>	