DIAGNOSTIC CYTOGENETICS INCORPORATED
1525 13th Ave. Seattle, WA 98122
800-328-2026 fax 206-325-2975
www.diagnosticcytogenetics.com

Patient Records Request

Fax Request for Laboratory Test Results

I,_____, request that Diagnostic Cytogenetics Inc provides me with a copy of:

_____ My laboratory test report from _____ (enter date of service)

_____ All protected health information on file

To verify your identity, please provide at least 4 of the following:

Social Security Number:_____

Date of Birth:_____

Phone Number:_____

Spouse/Next of Kin:_____

Ordering Physician:_____

Test Type:_____

Insurance Name/Number:_____

Employer Name:_____

Please select one of the following methods for result delivery:

___In-office pick up at Diagnostic Cytogenetics Inc: 1525 13th Ave., Seattle, WA 98122
Please call to make an appointment. Patient must provide one of the following methods of identification: valid driver's license, state ID card, passport

___Mail reports to:_____

___Fax reports to:_____

___Other method:_____

I understand that my results will be delivered to me within 30 days of this date and that I will be charged a minimal fee. Diagnostic Cytogenetics Inc is not responsible for interpreting my results.

Patient Signature :_____

Phone Number :_____ Date of Request :_____

(if signed by legal representative, please attach copy of power of attorney, etc.)

Results Delivery (for office use)

The above requested results were delivered to the patient on the following date:_____

_____ Mail _____ Fax _____ Other method:_____

_____ In-Office pick-up: _____
Patient Signature

Method of identification:_____

DCI Employee Signature: _____