DIAGNOSTIC CYTOGENETICS INCORPORATED
2292 West Commodore Way Ste 100 Seattle, WA 98199
800-328-2026 fax 206-325-2975
www.dxcyto.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: 2292 W Commodore Way Suite 100
Seattle WA 98199

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: ____