Form # Z-1016: Authorization to Disclose Patient Health Information for Continuity of Care

Patient Information:

Name (Last, First, MI)	
Date of Birth	
Requesting Facility MRN/ID#	

Purpose of Request:

Requested Results:

Molecular Testing Results Platelet Testing Results Reference Testing Results

Disclose Information from:

ImpactLife Reference Lab
Davenport 5500 LakeView Parkway Davenport, IA 52807 563-823-8933
Springfield 2801 S. 10th St Springfield, IL 62703 217-753-9443
St. Louis 3420 Rider Trail South Earth City, MO 63045 314-291-4752
Madison 6330A Copps Ave Monona, WI 53716 608-590-4073

Disclose Information to:

Requesting Physician	
Facility Name	
Facility Address	
Phone Number	
Method of Delivery:	
Fax Number	
Attention to:	
e-mail	
Attention to:	

Disclaimer:

The indicated test result(s) is being released at the request of the receiving provider for the purposes of patient treatment and continuity of care. The information contained is confidential and may include protected health information governed by federal and/or state privacy laws. Unauthorized use, disclosure, or further distribution of this information is prohibited.

The results provided reflect testing performed by ImpactLife's reference laboratory and are reported as finalized at the time of release. **The reference laboratory is not responsible for patient identification, demographic accuracy, or clerical errors that may have occurred prior to receipt of the specimen.** These results do not constitute a full medical record and may require confirmation with the ordering provider or originating facility.

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Physician Signature (or designee) Print Name Date