SUNRISE MEDICAL LABORATORIES
A Sonic Healthcare Company

PATIENT REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

Protected health information (PHI) maintained by Sunrise Medical Laboratories consists of medical records (test result report(s)) and billing records. Sunrise maintains separate records for each patient encounter. In response to this request, we will provide copies of your requested test result report(s) and/or billing information. **This information is also available from your physician and, with respect to billing information, your insurance carrier.**

The information provided on this request form will be used to search our records. The information in our records is provided by your physician at the time laboratory testing is ordered. If the information you provide does not exactly match the information in our records, we may not be able to locate and/or identify them. If there are any discrepancies, we cannot provide you with the requested records until the discrepancy has been resolved. To protect the privacy of all of our patients, we can only release PHI to you when the patient identifying information relating to you in our records exactly matches the patient identifying information you provide on this form.

We will respond within 30 days following receipt of this request.

PATIENT INFORMATION:

Name (include any names used at the time the testing covered by this request was performed):

First _____ **Middle** _____ **Last** _____

1. Date of Birth _____/_____/_____ **Sex:**_____

2. Patient's Address (at the time the laboratory testing was performed):

_____

3. Patient's Daytime Phone Number _____

4. Health Insurance Provider _____ **4. Insurance ID#:**_____

Records Requested:

Ordering Physician Name	Ordering Physician Address	Date(s) of Service

Indicate Requested Means of Delivery of Records (email, fax, mail or other), and provide email or mailing address or fax number:

☐ **Email** ☐ **Facsimile** ☐ **Mail** ☐ **Other**

_____

Authorization: (Incomplete requests will be denied.)
By signing below, you request that Sunrise Medical Laboratories search its records and provide you with a copy of the requested Protected Health Information maintained on you. This form must be accompanied by copies of two forms of ID. If this form is submitted in person at a Sunrise location, at least one of the IDs must be a photo ID. [In certain circumstances, a legal representative of the patient may request information on behalf of the patient. If you are the legal representative of the patient, please provide proof of identification and proof of your authority to act for the patient (court order, power of attorney, etc.)].

Printed Name _____

Relationship: (Check One)
☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Representative
(Provide a copy of proof of authorization)

_____
Signature **Date**

Contact us:

Please submit this form (along with proof of identification and, if required, proof of representation) to:

Sunrise Medical Laboratories, Inc.
250 Miller Place
Hicksville, NY 11801
Attention: Customer Service
Facsimile: 1-631-435-1552
Email: customerservice@sunriselab.com

Sunrise Use Only

Date Rec'd: _____ **ID Verified (initials):** _____

Date Provided/Initials:_____

Mode of Transmission: _____

Accession #(s):

_____

***********Two forms of ID Must Accompany All Requests***********