



## Instructions for Obtaining Records of Laboratory Testing (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 your request, we will provide copies of your requested test result report(s) and/or billing information. **Test result information is also available from your physician and billing information, from your health care insurer.**

The information provided on the 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. 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 or, in case there are discrepancies, we are able to resolve them.

**We will endeavor to get you the requested information as soon as possible, and we can assure you that we will respond no later than 30 days following receipt of your request.**

**When the request form is completed, please submit it to Sunrise. The form must be accompanied by proof of identification (two forms, including least one valid photo ID) and, if you are signing as a legal representative of the patient, documentation of your authority to act for the patient (for example, an authorization signed by the patient, a power of attorney, letters testamentary or letters of administration, or another official legal document). The request form and any supporting documentation should be directed to either of the following locations:**

**Sunrise Medical Laboratories, Inc.  
250 Miller Place  
Hicksville, NY 11801  
Attention: Customer Service  
Facsimile: 631.435.1552  
Email: [CustomerService@sunriselab.com](mailto:CustomerService@sunriselab.com)**

**Sunrise Medical Laboratories, Inc.  
4200 Pleasant Valley Road  
Chantilly, VA 20151  
Attention: Customer Service  
Facsimile: 703.818.6453  
Email: [ChantillyService@sunriselab.com](mailto:ChantillyService@sunriselab.com)**



**PATIENT REQUEST TO ACCESS  
PROTECTED HEALTH INFORMATION (PHI)**

**PATIENT INFORMATION:**

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

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address (at the time the laboratory testing was performed):

\_\_\_\_\_

Daytime Phone Number(s): \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

**Records Requested:**

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

**Requested Means of Delivery:**

<input type="checkbox"/> Mail	Address:
<input type="checkbox"/> Email	Address:
<input type="checkbox"/> Fax	Number:

**Authorization:**

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. See the Instructions for further information regarding the documentation required to be submitted with this form.

Printed Name \_\_\_\_\_

Relationship to Patient: (Check One)

Self  Parent  Legal Guardian  Legal Representative

(Provide a copy of proof of authorization)

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Sunrise Use Only**

Date Received: \_\_\_\_\_ ID Verified (initials): \_\_\_\_\_

Date(s) Communicated with Requester: \_\_\_\_\_

Date Requested Records Provided/Initials: \_\_\_\_\_

Mode of Transmission: \_\_\_\_\_

Accession #(s): \_\_\_\_\_

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