

Information for patients

Record Request Form

Instructions for Record Request Form

- Patient Information:
 - Information is for the person whose records are being requested. Name, address, date of birth and gender are required. Phone contact information and Insurance ID number will be helpful.
- Medical Records Requested
 - Check the first box for results of lab tests collected or dropped off today.
 - If older records are requested, give as much detail as possible about the records. Indicate ordering physician name, city and state as well as month and year the tests were run.
- Method of Transmission

 If the records are being sent to someone other than you, please enter the name of the person to receive the records. The records can be sent to you in several different ways:
 - Please indicate your preferred way to receive the records.
 - Give the appropriate address for the format you choose.
- Signature
 All requests must be signed and dated. If the person requesting the records is not the patient, please indicate what the relationship is between the requestor and the patient. Legal guardians and personal representatives must provide written documentation to prove the authority to access the records.

This form can be left at the America Esoteric Laboratories (AEL) Patient Service Center, if all documentation is available. Please provide a valid picture identification to expedite the process.



Alternatively, the form may be mailed, emailed or faxed to AEL along with a copy of two forms of identification (Driver's license or State Identification card, Insurance card, Military ID, Social Security card, Passport, US Tribal or Bureau of Indian Affairs ID card, Certification of Citizenship – N560, Employee Authorization card). See bottom of form for submission information.

Fax: 901.844.8669

Mail: AEL Customer Service 1701 Century Center Cove Memphis, TN 38134 **Phone:** 901.405.8200 or 800.423.0504





Record Request Form

*Indicates REQUIRED Information

Patient Informati	on				
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*Last Name	*First Name	MI	*Date of Birth	*Sex	
Other names to search (nicknames, former names, etc.)		Insurance	e I.D. Cell Pho	ne or Other Primary Phone	
*Address					
Please Indicate t	he Medical Records Requested				
☐ Results of the laborate	oratory tests collected or dropped off too	day	da	ite	
	fied below, Include:	,			
_ The reduce open	noa solow, molado.				
Ordering Physician:	Physician Full Addre	Physician Full Address		Date of Service Month and Year	
☐ Other records, spe	ecify records requested and appropriate	e date of ser	vice		
Please Select On	e of the Following Methods for	Transmis	ssion:		
*Send to (enter name in *By (please mark one)	f different from above)				
* *					
□ Fax Number Mail (enter address if different than above)					
☐ Email address:** _					
	**Note: Email is not recommended	due to securi	ty; if requested, security is	at the risk of the requestor.	
☐ Pick up at PSC (sp	ecify location)				
My signature below auth	orizes AEL to release the records containing Prote	ected Health I	nformation I have request	ed. Two forms of ID are attached.	
*Signature			Date:		
*Printed Name			Initials:		
*Relationship: Self Self	Parent 🔲 Legal Guardian (provide proof) 🔲 P	ersonal Repre	sentative (provide proof)		
Internal Use Only PSC ID:					