AMERICAN ESOTERIC LABORATORIES

A Sonic Healthcare Clinical Laboratory

Information for patients

Record Request Form

Instructions for Record Request Form

1 **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.

2 **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.

3 **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.

4 **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.

Mail: AEL Customer Service
1701 Century Center Cove
Memphis, TN 38134

Fax: 901.844.8669

Phone: 901.405.8200 or
800.423.0504

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*Indicates REQUIRED Information

Patient Information

*Last Name | *First Name | MI | *Date of Birth | *Sex

Other names to search (nicknames, former names, etc.) | Insurance I.D. | Cell Phone or Other Primary Phone

*Address

Please Indicate the Medical Records Requested

☐ Results of the laboratory tests collected or dropped off today _____ date

☐ Prior results specified below, Include:

Ordering Physician:	Physician Full Address	Date of Service Month and Year

☐ Other records, specify records requested and appropriate date of service _____

Please Select One of the Following Methods for Transmission:

*Send to (enter name if different from above) _____

*By (*please mark one*)

☐ Fax Number _____

☐ Mail (enter address if different than above) _____

☐ Email address:** _____

**Note: Email is not recommended due to security; if requested, security is at the risk of the requestor.

☐ Pick up at PSC (specify location) _____

My signature below authorizes AEL to release the records containing Protected Health Information I have requested. Two forms of ID are attached.

*Signature _____ Date: _____

*Printed Name _____ Initials: _____

*Relationship: ☐ Self ☐ Parent ☐ Legal Guardian (provide proof) ☐ Personal Representative (provide proof)

Internal Use Only
PSC ID: _____ Photo ID Verified by: _____

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