FAX

Date:

To: Facility:

Fax:

From: Phone:

Pages:

My Information:

Name: DOB:

Test Information:

Type of Test: Date of Test:

Request:

- [ ] Copy of Test Results
- [ ] Explanation of Results
- [ ] Follow-up Appointment
- [ ] Other:

Message:

CONFIDENTIALITY AND PRIVILEGE NOTICE: This fax contains my personal medical information. It is intended only for my healthcare provider named above. If you are not the intended recipient, please notify me immediately at the phone number listed and securely destroy this document. Unauthorized disclosure is prohibited by HIPAA regulations.