LAB RESULTS REQUEST FORM

Copy to Client and/or Physician

Date:________/_________/__________

Client Name:____

SS#:_________/_________/____________ Date of Birth:________/_______/__________

Carrier Name:____

To whom it may concern:

I formally request that a copy of my Lab Results be copied to me directly at my home address of:

Name:____

Address:____

City:____ State:_________ Zip:_______________

And/or to my Personal Physician at:

Name:____

Business Name:____

Address:____

City:____ State:_________ Zip:_______________

Remarks:____

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Client's Signature/Guardian or Custodian/Authorized Representative