Associates for Women's Medicine

PATIENT REQUEST FOR COPIES OF THEIR LABORATORY RESULTS

Please Print

Patient's Name: _____

Patient's DOB: _____

Patient's Address: _____

Ordering Provider: _____

Date of Service: _____

Requested By: _____ **Phone #:** _____

Relationship to Patient: _____
If Requested by Patient Representative

Signature: _____ **Date:** _____

FAX COMPLETED FORM TO THE LAB 703-8002

(Note: The laboratory will have up to 30 days to comply with the request.)

For Office Use Only

Tech Code: _____Reviewed By:_____Approved By:_____Date Completed:_____

Notes: