Test Results Request Form

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Address: _____

I authorize Addiction Care of Excellence to deliver my test results to me

☐ By Fax – the fax number is _____.

☐ By Email – the email address is _____.
I understand that email is not secured to the standard required by the HIPAA law. I fully understand the risk of transmitting my confidential health information through email. I have been advised to consult my attorney and information technology specialists to address my concerns. I will hold no harm against Addiction Care of Excellence and the staff for any loss that might incur from delivery of test results through email.

☐ By Mail – Please enclose a self-addressed envelop with sufficient postage.

Patient Signature: _____ OR

Signature of Legal representative: _____
(Copy of Power of Attorney for Health Care must be attached)

Date: _____