UDL UNIVERSAL DIAGNOSTIC LABORATORIES

AUTHORIZATION FOR RELEASE OF TEST REPORTS TO PATIENT

I, the undersigned patient, authorize Universal Diagnostic Laboratories ("UDL"), to release to me the reports of testing UDL performed on specimens from me pursuant to an order(s) by my physician.

- ☐ This authorization covers release of the test reports to me in person
- ☐ This authorization covers release of the test reports to me by mail at the address listed below.
- ☐ This authorization covers release of the test reports to me by email address at the email address listed below.
- ☐ This authorization covers release of the test reports to me by facsimile at the telephone number listed below.

I understand and agree that UDL has the right and obligation to authenticate that I am the patient, for whom this authorization has been made and that if UDL is unable to make such authentication, UDL will not disclose and is under no obligation to disclose the requested test reports. I understand and agree that by providing this authorization for the release of test reports by mail, email or facsimile, other persons, including, but not limited to, members of my family, may have access to my test reports.

If I have any questions regarding test reports that have been released to me, I understand that my questions should be referred to my Physician.

I hereby release UDL and its directors, officers, employees and agents from all liability and all claims of any nature whatsoever pertaining to disclosure of my test results to me.

Date of request:_____
Patient Name: (print) _____
Patient's Signature:_____
Address:_____
Email Address:_____
Facsimile Number:_____
Attach copy of designated person's photo ID, e.g., driver's license.

PATIENT INFORMATION
Patient's name (print):
Date of Birth:
Date of Service:
Test Name(s):
Ordering Physician and address:

PLEASE FAX COMPLETED FORM & ID TO 818-849-5442 OR EMAIL CS@UDLAB.COM