DIAGNOSTIC LABORATORY OF OKLAHOMA

NON-ORDERING TREATING HEALTH CARE PROVIDER REQUEST FOR LABORATORY REPORTS

TO: Diagnostic Laboratory of Oklahoma

I am currently treating the patient identified below, and I am requesting the following laboratory test result(s) for that patient, which were ordered by another health care provider, be released to me solely for treatment purposes.

(Note to Non-Ordering Health Care Provider: Diagnostic Laboratory of Oklahoma ("DLO") relies on information provided by the ordering clinician at the time the laboratory test is ordered. The information provided by the ordering clinician may not be sufficient to accurately match the information you provide on this request form. In such cases, DLO will protect our patients' privacy by *not* releasing results that do not conform to our strict criteria for determining matches. Therefore, although the information you provide in this request may assist us to positively identify records, there is no guarantee that all records will be identified. Failure to provide all information we request below may prevent us from identifying some or all of the patient's records.)

TREATING HEALTH CARE PROVIDER (**BOLD TYPE** Indicates Required Information. Incomplete requests will be denied.) **REQUIRED**

Treating Provider's Name_____ Phone Number **( )** _____
First Name Middle Name Last Name

Treating Provider's Address: (This is the address where the response will be sent) **DLO Account #**_____

OR

Street_____ **NPI #**_____

City_____ ____ **State** _____ **ZIP**_____

PATIENT'S INFORMATION (**BOLD TYPE** Indicates Required Information. Incomplete requests will be denied.) **REQUIRED**

Patient's Name_____ Phone Number (_____) _____ Daytime
First Name Middle Name Last Name (_____) _____ Evening

All other Names (nicknames, alternate spellings, maiden name, etc.) **Gender** ☐ Male ☐ Female

_____ **Date of Birth** _____
(MM/DD/YYYY)

Patient's Address: Social Security # (last 4 digits)_____
(Not required, but may help us to match records)

Street_____

Insurance ID#_____
(Not required, but may help us to match records)

City_____**State** _____ **ZIP**_____

LABORATORY INFORMATION REQUESTED (**BOLD TYPE** Indicates Required Information. Incomplete requests will be denied.) **REQUIRED**

Date(s) of Service:_____ **Test(s) Performed**:_____

Ordering Physician's Name_____ Phone Number (_____) _____
First Name Middle Name Last Name

Ordering Physician's Address**:**

Street _____

City_____State_____ ZIP_____

TREATING PROVIDER'S SIGNATURE (**BOLD TYPE** Indicates Required Information. Incomplete requests will be denied.) **REQUIRED**

By signing below I request that DLO search its electronic records and provide me with copies of matching records maintained on the above referenced patient. An authorized designee of the treating provider may request information on behalf of the provider.

_____
Signature **Date**

_____
Print Name and Title