Patient Request for BIOTAP Medical Test Results

716 W. Main Street, Suite 2-S, Louisville KY 40202
Phone: 502-566-3588 Fax: 502-566-3591 CLIA# 18D2037709

Patient and Physician Information

Patient Name: (Last, First, MI)	**Birth Date:** (MM/DD/YYYY)	**Phone:** (including area code)

Your Physician's Name:	**Date of Collection:** ***(approximate)***

Preferred Delivery Method

Please choose one

☐ **U.S. Mail**	Name:
	Address:
	City/State/Zip:
	Phone:
☐ **Secure Email**	Email Address:
☐ **Fax**	Fax Number:

Patient Consent

I am requesting a copy of my ☐ toxicology ☐ pharmacogenetics test results. I understand this test was ordered by the provider listed above and that my sample was sent to BIOTAP Medical for testing.

In order to protect my privacy, I understand the results will be delivered in accordance with all applicable state and federal regulations. If I have requested that the results be delivered by standard mail, I understand that I must provide a signature to take delivery of the report. If I have requested that the results be delivered electronically, I understand that I will need to have access to a computer and the internet, and that I will be required to log onto a secure website in order to download the results. If I have requested that the results be faxed, I understand that I will need a secure fax machine/number at which I can receive the report.

I understand that once I have requested the results, and once BIOTAP Medical has sent the report in the manner I have prescribed above, I will then be responsible for the safe-keeping of this personal health information and will hold harmless BIOTAP Medical for any manner in which it may be disseminated once in my possession.

Furthermore, I understand these toxicology/genetic test results represent only a small part of my total health picture, and that results of this nature should *always* be interpreted in context of my complete personal health record, to include any medications I am currently taking. **I understand that I should in no way alter my health regimen/treatment plan after receiving these test results without first consulting with my health care provider**.

By signing below I certify that I am the person whose name and address appears on this form. I may be asked to provide a copy of a government-issued ID as proof of my identify. If I am a legal guardian or representative of said patient, I understand that I will be asked to provide additional documentation proving this relationship.

_____	_____	_____
Signature of patient or legal guardian	Printed name	Date

PLEASE NOTE: A signature is required to process this request. Please print, sign, and fax or mail this document to BIOTAP Medical. (See the top of this page for fax# & address.)