Request to Disclose Protected Health Information

ProPath®

ProPath Services, LLC
ProPath Associates, PLLC

In order for us to identify the requested patient report(s), please complete all required information. Using the information provided, we will attempt to identify the laboratory test results.

*Indicates REQUIRED information.

A. PATIENT INFORMATION

Name*: _____
First Name M.I. Last Name

All other Names* (nicknames, alternate spellings, former name, etc.):_____

Date of Birth*: _____ Phone: _____

Address*: _____

_____

SS# (last four digits): _____ Insurance ID#: _____

B. TEST INFORMATION

Ordering Physician (or Office) Name(s)*: _____

Ordering Physician's Address(s)*: _____

_____

Approximate Date(s) of Service*: (MM/DD/YY) _____

Ordering Physician's Phone(s): _____

C. AUTHORIZATION

By my signature, I request that ProPath search its records and provide me or the individual I request in box D below, with a copy of the patient report(s) requested. NOTE: If you are a legal representative of the patient please provide proof of representation as requested (healthcare proxy, court order, power of attorney, etc.).

Printed Name*: _____

Relationship*: (Check One) ☐ Self ☐ Parent ☐ Legal Guardian (Provide Proof) ☐ Legal Representative (Provide Proof)

Signature*: _____ Date*: _____

D. DELIVERY

Send to (Name)*: _____

Address (If different than above)*: _____

_____

or Fax Number: _____ or Email address: _____

Please submit this completed form (and any proof of representation, if required) to:
ProPath Services, LLC, 1355 River Bend Drive, Dallas, Texas 75247, ATTN: Patient Services
or fax to: 214-237-1731

ProPath will respond within 30 days of receipt of this request.