PATIENT REQUEST FOR RELEASE OF LABORATORY TEST RESULTS

Montana Department of Public Health and Human Services
Public Health Laboratory
1400 Broadway, Room B206
Helena, MT 59601
Telephone: 1-800-821-7284
Fax: 406-444-1802

The Montana Public Health Laboratory will provide test reports within 10 business days of receiving the completed test request form. A government issued photo ID which establishes the identity of the individual making the request and their legal right to obtain the test reports must be presented when bringing a request to the Laboratory Services Business Office or to a notary public prior to faxing or mailing a request. This information, as well as the information requested below are required to ensure that your private health information is protected in compliance with HIPPA guidelines.

Please provide the following information:

Patient's Name: _____

Patient's Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Phone number: _____

Provider: _____Phone: _____

Type of Test: _____

If Sickle Cell Trait, provide mother's maiden name: _____

Approximate Date Test performed: _____

Signature and Date: _____
If patient is under 18 years old, a parent or legal designated guardian must present identification or other documentation that establishes the right to have the patient's protected healthcare information.

If Parent or Guardian, Please Print Name: _____

Verification of Identity:
If request is mailed or faxed, provide Notary Seal,

Notary Signature and Date: _____

If request made in person, identification or other documentation verified by _____

If report is to be sent to an alternate address, please provide that information below:

Name: _____

Address: _____City, State, Zip: _____

Phone: _____Fax: _____

For Office Use Only

Date Request Received: _____

Date Request Mailed: _____

Staff Who Completed Request: _____