Patient Request for BIOTAP Medical Test Results

716 W. Main Street, Suite 100A, Louisville KY 40202
Phone: 502.566.3588 Fax: 502.561.0089 CLIA#: 18D2037709

BIOTAP MEDICAL

Patient and Physician Information

Patient Name: (Last, First, MI)	**Pt. Birth Date:** (MM/DD/YYYY)	**Pt. 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 understand a laboratory test was ordered for me by the provider listed above and that my sample was sent to BIOTAP Medical for testing. I am requesting a copy of the following test results:

☐ toxicology ☐ serology (blood) ☐ COVID-19
☐ pharmacogenetics ☐ STI (sexually transmitted infection) ☐ UTI (urinary tract infection)

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 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/serological/molecular test result 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 identity. 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 top of page for fax# & address.)