Authorization to Disclose Protected Health Information

I, _____
(Print name)
Authorize PBM Laboratories to disclose to me a copy of my pathology report, as specified below.

I, the undersigned, certify that I am the patient on whom the tests were performed. My address, phone number, and Driver's license number/State issued ID numbers are:

_____
(Address)
State issued Driver's License # _____ or State ID#: _____

___ Please mail my results to my address above.

___ I will personally pick up my report at (Circle location)
Dallas Lewisville Plano McKinney Grapevine Waxahachie

___ Please fax to: _____

___ Please email to: _____

___ My legally authorized representative: Name _____,
DL# or State ID#: _____ Relationship:_____ will personally pick up my report at (Circle location)
Dallas Lewisville Plano McKinney Grapevine Waxahachie

Date of procedure: _____ Daytime phone: _____

Patient signature: _____ Date: _____

PLEASE NOTE: A DRIVER'S LICENSE WITH MATCHING ADDRESS, OR OTHER STATE ISSUED PICTURE ID IS REQUIRED ALONG WITH THIS FORM, FOR THE RELEASE OF RECORDS.

You can fax the authorization along with picture ID to: 972-966-7899

Email requests can be sent to: patientrecords@pbmlabs.com

If picking up in person, please specify the location.

Dallas Location	**Lewisville Location**
3600 Gaston Ave #261	2501 S. State Hwy 121 Business #1210
Dallas, TX 75246	Lewisville, TX 75067
P: 214-818-9100	P: 972-966-7827
Wadley Tower on the Baylor Campus	*GPS/Map Address: 420 W. Round Grove Rd., Lewisville, TX 75067 (Convergence Center)*

For all other locations please call for address.

Medical Director/Site Pathologist Signature: _____ Date: _____