EL PASO PAIN CENTER
Comprehensive Health & Wellness

3215 Gateway Blvd W
El Paso, TX 79903
T. 915-598-PAIN (7246)
F. 915-633-6598

Petition to Release Laboratory Reports to Patients

Patient's Name (First, Middle, Last)	Birth Date (MM/DD/YYYY)
MRN #	Accession # (Laboratory)
Physician's Name (First, Middle, Last)	

Instructions: If **any** section is incomplete, this form may be invalid.

Release Information From	**Release Information To**
☐ El Paso Pain Center, 3215 Gateway Blvd. West El Paso TX 79903 ☐ Other (Specify facility/individual & address below, including phone/fax if known.) _____ _____ _____ _____	☐ Specify facility/individual & address below, including phone/fax if known.) _____ _____ _____ _____

Purpose of Release

☐ Treatment/Continued Care	☐ Personal	☐ Legal Purposes
☐ Application for Insurance	☐ Disability Determination	☐ Payment of Insurance Claim
☐ Other _____		
_____		

Information to be Released

Service Dates From: To:		Information Needed By
☐ Toxicology Report	☐ Pharmacogenomics Report	☐ Clinical lab Report

I understand that Presidio Laboratories is not required to interpret laboratory test results to the patient. The laboratory will continue to refer patients back to their provider for interpretation. The laboratory will provide a copy of the patient's laboratory results in a PDF format. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.**

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ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the Patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship.
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ☐ Parent ☐ Legal Guardian

Signature *(Required)*	**Date Signed** *(Required)* (MM/DD/YYY)
Printed Name of Person Signing *(If Not Patient)*	
Name of personnel authorizing the release of the laboratory report:	
Signature *(Required)*	**Date Signed** *(Required)* (MM/DD/YYY)