ACL laboratories
8901 West Lincoln Avenue
West Allis, WI 53227
1-800-877-7016

AUTHORIZATION TO RELEASE PATIENT RESULTS

1) _____
Name | Address | City | State | Zip

_____
Date of birth | Fax Number | Email Address

2) **Authorizes** ACL Laboratories, 8901 West Lincoln Avenue, West Allis, WI 53227

3) **To disclose to**:

☐ **Self, via** ☐ Mail (USPS) ☐ email (encrypted) ☐ Fax ☐ Other, specify:

☐ **Other** (I authorize _____ to pick up my records). **Photo ID required**

☐ _____
Health Care Provider / Plan / Facility Name Address

_____
City | State | Zip | Fax Number

4) **Date(s) of information to be disclosed**: From _____ to _____
(month/year) (month/year)

5) **Information to be disclosed** (check all that apply):

☐ Laboratory Reports ☐ Pathology Reports
☐ Billing Records ☐ Pathology Billing Records
☐ Other _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

☐ Alcohol/Drug Reports ☐ HIV Test Results ☐ Mental Health/Developmental Disability

6) **Expiration**: This Authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **Purpose** (check all that apply): ☐ Further Medical Care ☐ Personal (at my request)
☐ Insurance Eligibility/Benefits ☐ Legal Investigation/Action ☐ Other: _____

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by the Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the ACL Compliance department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **Signature of Patient / Legal Representative**:

_____
Signature Date

If signed by a person other than the patient, complete the following:

Legal authority: ☐ Parent placement of this minor.

☐ Legal Guardian ☐ Next of kin/executor of deceased ☐ Health Care POA

representation

Submit completed form (and any proof of representation, if required) to:

ACL Client Services email: ACLPatientResultRequest@aurora.org Fax: (800) 372-5670 or (414) 328-7676

8901 West Lincoln Avenue, West Allis WI 53227 ACL will respond within 30 days of receipt of the request

Internal Use: Date received: _____ Date sent: _____ Tech: _____