CLINICAL REFERENCE® LABORATORY

Request for Access

Effective date of this notice: 04/16/2020

Individual Name: _____
Individual Address _____
Date of Birth: _____
SSN or ID No: _____
Specimen Identification No: _____

Please consider this a request for the exercise of my rights under federal and state laws to request confidential communications of my Personal Information. I understand that my request will be reviewed and that in some circumstances I may not have the right to access all information. I understand that my request will be acted upon as quickly as possible but no later than the timeframes allowed by the laws of my state. I further understand that I will be contacted when my records are available for inspection.

Date of Request (mm/dd/yyyy)	Describe the information you want to inspect or review	Provide the dates you would like to review

How would you like to review this information?
☐ Copies mailed to me at the address above
☐ Copies mailed to me at this address _____ _____ _____
☐ Review the records at CRL's offices
☐ Via Secure Email to my email address at _____

I understand that the provider to whom I am making this request if permitted under certain circumstances to deny me access to my records. This includes photocopy notes, information related to civil, criminal, or administrative actions or proceedings, or information obtained from someone other than a healthcare provider under a promise of confidentiality.

Signature: _____ Date: _____

Please Mail Form to:
Clinical Reference Laboratory, Inc. Attn: Privacy Officer, 8433 Quivira Road Lenexa, KS 66215