CLINICAL REFERENCE® LABORATORY

Request for Accounting

Effective date of this notice: 10/01/2020

Individual Name: _____
Individual Address _____
Date of Birth: _____
SSN: _____
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

Describe the Personal Information for which you would like an accounting.

Date Range of this Request

From _____ to _____

Please consider this a request for an accounting of all disclosures for the time frames indicated below. (The maximum time frame that can be requested is six (6) years prior to the date of the request, but not before April 14, 2003.)

Signature: _____ **Date:** _____

To Safeguard your privacy and help make sure no one else is requesting access to your information, this request must be notarized. (Notary Services can often be provided free of charge where you bank.)

_____ **My Commission Expires:**

NOTARY PUBLIC _____

In and for the County of: _____
State of: _____
Printed Name: _____

Please Mail Form to:
Clinical Reference Laboratory, Inc. Attn: Privacy Officer, 8433 Quivira Road Lenexa, KS 66215
or Fax to: 855.691.4001