APOLLO LABORATORIES

Patient Request for Release of Results

In order to locate your laboratory results, the following information is required. (Print)

Patient Name_____
Last First Middle

_____
Other Names or Alternate Spellings

Address_____

Phone Number_____
Home Cell

Date of Birth _____ SS# (Last Four) _____ Driver's License (State) ____ # _____

Test Name(s) _____

Date(s) of Service _____

Ordering Physician(s) _____ Phone Number_____

Address_____

I authorize Apollo Laboratories to release the requested lab results as attested by my signature below. (If the results are to be released to a legal representative, please provide proof of representation*- court order, power of attorney)

Printed Name _____ Relationship ___ Self ___ Legal Guardian*

Signature _____ ____ Parent ____ Legal Representative*

Recipient Name(s) _____

Address _____

OR Fax _____ ***OR*** Email _____

Please submit request to Apollo Laboratories, Crown Drive, #1330, Farmers Branch, Texas 75234 or fax to 214-871-8647.
Results will be sent within thirty days of receipt of request.