



Arizona Department of Health Services  
Bureau of State Laboratory Services

### Test Results Request Form

Each requesting test results (Requestor) must submit a completed Test Results Request Form.  
Please include a self-addressed stamped envelope with your request

Requests will not be considered until the written request form is submitted.

Date of Request: \_\_\_\_\_

NAME OF PATIENT: \_\_\_\_\_  
Last First Middle

Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

Patient's Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip Code

**Requested Test Results:**  Newborn Screening  Other clinical (Specify the test/ tests and approximate date of the test/tests below)

<u>Test/Tests</u>	<u>Approximate Date of the Test/Tests</u>
_____	_____
_____	_____
_____	_____
_____	_____

Name of Requestor: \_\_\_\_\_  
(if different than patient) Last First Middle

Requestor's Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip Code  
\_\_\_\_\_  
Phone E-mail (optional)

BY SIGNING BELOW I ACKNOWLEDGE THAT I AM LEGALLY AUTHORIZED TO REQUEST PROTECTED HEALTH INFORMATION (PHI) AND WILL PROVIDE DOCUMENTATION OF AUTHORITY TO RECEIVE PHI

Requestor Signature:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date