PROTECTED HEALTH INFORMATION REQUEST



All sections of the form must be completed in order for PinPoint Testing-Florida to fulfill the request.

REQUESTED PHI ☐ LABORATORY TEST RESULTS ☐ ORDER FORM ☐ OTHE	ER:	□ тох
I,, request that PinPoint specimen sent on to PinPoint Testing-Florida for interpretation of results of the testing that has been ordered.		· ·
Please complete the section below ONLY if you are the patient's des	signated representative. *E	OOCUMENTATION WILL BE REQUIRED
I, the personal representative the authority under applicable law to make health care decision documents along with this request to support that authority (health care).	s for the individual listed abo	ve. I have provided copies of the following
By my signature, I request that PinPoint Testing-Florida search its recommon box below, with a copy of the PHI requested. NOTE: If you are a legal representative of the patient please provide power of attorney, etc.).		
RELATIONSHIP (CHECK ONE): SELF PARENT LEGAL GUA	ARDIAN* LEGAL REPRES	ENTATIVE*
PRINTED NAME		
SIGNATURE	DATE	
PATIENT INFORMATION		
FULL NAME	PHONE NUMBER	DATE OF BIRTH
ADDRESS	CITY	
STATE ZIP CODE	INSURANCE ID #	DATE OF SERVICE
TEST ORDER INFORMATION		
ORDERING PROVIDER NAME	FACILITY/PRACTICE NAME	
ORDERING PROVIDER ADDRESS	CITY	STATE ZIP CODE
ORDERING PROVIDER PHONE NUMBER	PINPOINT ACCOUNT NUMBER	
DELIVERY INSTRUCTIONS FOR LABORATORY TEST RESULTS OF	R ORDER FORM	
SEND TO (NAME)	FAX NUMBER	
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE ZIP CODE
Please submit the completed form (and any proof of representation,	Internal use o	nly:
f required) to: PinPoint Testing-Florida	Date received	l: Tracking #:
4201 Vineland Road, Suite I-12 Orlando, Florida 32811	Date sent:	Initials:
ATTN: Client Services	Account #:	Req #: