



## Release of Medical Information

To request release of medical information, please complete and sign this form and return it to:

Laboratory Records Department  
Trace Elements  
4501 Sunbelt Drive  
Addison, Texas 75001

You may also submit this form by Fax to:  
972-248-4896 or you may scan and send via e-mail  
to: [teilab@traceelements.com](mailto:teilab@traceelements.com)

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

(Health Professional currently on record)

Name: \_\_\_\_\_ Degree(s): \_\_\_\_\_ TEI Account #: \_\_\_\_\_

**Trace Elements has my permission to release or disclose the following Protected Health Information (PHI)\* for the above named patient.**

\* Copies of any and all records, laboratory reports, or any other information concerning medical history, diagnosis, recommended treatment and prognosis.

**Trace Elements will make available for release or disclosure the information requested above to the following Health Professional:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Degree(s): \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

TEI Account # (if applicable): \_\_\_\_\_

In the event that Trace Elements is requested to provide printed reports or documentation, I understand and accept that there may be a charge for any resending of previous laboratory reports and duplication of records at the rate of \$ 5.00 per report or record, and payment will be due at time of request. Printing and/or duplication of records will be processed within five (5) business days of receipt of payment.

I authorize the use of fax or scanned/e-mail attachment for the release or disclosure of the information described above.

I understand and accept the above request for release and disclosure of personal medical information in its entirety. I further understand that I can cancel this release in writing at any time.

\_\_\_\_\_  
**Signature of Patient (if 18 years of age or older)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent or Guardian (if minor patient)**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**