Result Release Form

While I, the customer, understand that Request A Test, Ltd. does not encourage the use of faxing as a routine reporting method of confidential results, I request my medical results be faxed to the number listed below. This form authorizes Request A Test, LTD. to fax the specified test results on my behalf. It also authorizes future faxes to the same number upon a verbal request by me, for up to one calendar year from the signature date.

I certify that the fax number is in a secure area. Request A Test cannot be held responsible if the fax is unsuccessful or if the receiving party does not receive the fax for any reason.

I agree to defend, indemnify, and hold Request A Test, Ltd. wholly harmless from and against all costs (including reasonable attorney's fees), liabilities, and expenses arising out of wrongful disclosure, breach of confidentiality of the misuse of my information.

Customer Name:____

(Please Print) First Name Last Name

Date of Birth:_______________________________ Month/Year of Test:___________________________

Signature (e-signatures not accepted):_____________________________Date:_____________________

Please fax results to: ________________________________Attn:______________________________

Return completed form along with a copy of your photo ID to Request A Test

Fax form to: 1-440-717-0540
Email form to: customerservice@requestatest.com

****Please be sure to send a copy of your photo ID with your form****

7027 mill road suite 201, Brecksville, OH 44141— 1-888-732-2348
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