

Information for patients

Record Request Form

1. Patient Information:

Information is for the person whose records are being requested. Name, address, date of birth, and gender are required. Phone contact information and insurance ID number will be helpful.

2. Medical Records Requested

Give as much detail as possible about the records being requested. Indicate ordering physician name, city and state, as well as month and year the tests were run.

3. Method of Transmission

If the records are being sent to someone other than you, please enter the name of the person to receive the records.

The records can be sent to you in several different ways:

- Please indicate your preferred way to receive the records.
- Give the appropriate address for the format you choose.

4. Signature

All requests must be signed and dated. If the person requesting the records is not the patient, please indicate what the relationship is between the requestor and the patient. Legal guardians and personal representatives must provide written documentation to prove their authority to access the records.

This form can be taken to an East Side Clinical Laboratory (ESCL) Patient Service Center. Please provide a valid picture identification to expedite the process.

Alternatively, the form may be mailed, emailed, or faxed to ESCL along with a copy of two forms of identification (driver's license or state identification card, insurance card, military ID, social security card, passport, US Tribal or Bureau of Indian Affairs ID card, certification of citizenship – N560, employee authorization card). See bottom of form for submission information.

RECORD REQUEST FORM *Indicates REQUIRED Information

1. Patient Information (*Please Print*)

*Name - Last	*First	MI
Other names to search (maider	n name, nicknames, former names, etc.)	
* 4 days as		
*Address		
Insurance I.D.	Cell Phone or Other Primar	ry Phone Internal Use Only
*Date of Birth	*Biological Sex	Picture ID verified by
	Female Male	,

2. Request for reports specified below

Ordering Physician Name	Ordering Physician City & State	Date of Service Month & Year	

3. Please Select the Following Method for Transmission:

*Send to (enter name if diff	erent from above):			
*By (please mark one):				
Email Address:				
Pick up at PSC (speci	ify location):			
4. *Signature			*Date	
*Printed Name:	(Provide Proof)			
*Relationship:	Self	Parent	Legal Guardian	Personal Representative

For Information, or to submit form: East Side Clinical Laboratories

10 Risho Avenue, East Providence, RI 02914 | Client Services Department Phone: 401.455.8400 | Fax: 401.400.7044

ESCL will use best efforts to respond within 2 weeks of request unless testing requires extended period of time. For patient safety, any changes to information requires a new form to be completed.



East Side Clinical Laboratories 10 Risho Avenue East Providence, RI 02914 www.eastsidelab.com P: 401.455.8400

(Initials)

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