



## **Authorization to Release Unreviewed Labs**

I request that I receive copies of my laboratory tests ordered by Dr. Harvey prior to his review and recommendations. I choose not to review them with Dr. Harvey at this time, and I take full responsibility for them. I release Dr. Harvey of any medical responsibility and liability.

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date: \_\_\_\_\_

Results Requested: \_\_\_\_\_

\_\_\_\_\_

I would like these results: (Please select One Below)

\_\_\_\_\_ Faxed to \_\_\_\_\_

\_\_\_\_\_ Ready for pick up by \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_