CENTRAL COAST
PATHOLOGY LABORATORY
A Sonic Healthcare Company

Instructions

1. Download and complete the PERSONAL INFORMATION and DELIVERY INSTRUCTIONS sections and sign the Medical Records Request and Release form.
2. Present the form along with a photo identification to any CCPL location for processing. Authorized representatives must provide supporting documentation to that effect, i.e. Patient Authorization, Power of Attorney, Certificate of Conservatorship, etc. You may also email this request and supporting documentation to PatientRecords@ccpathology.com, or fax ATTN: Client Service Department, (805) 787-0104. In most instances, requests will be processed upon receipt of required documentation.

Please note that while most requests are processed immediately upon receipt in their respective department, under California State Law, the laboratory has 15 days in which to fulfill each request. Furthermore, some requests may require additional processing time in addition to the initial 15 days. If applicable, you will be notified.

Advice to Patients Receiving Clinical Laboratory Results

Appropriate medical expertise is required for the correct interpretation of clinical laboratory results, and is not available from laboratory personnel. Caution is urged in regard to individual interpretation of these clinical laboratory results.

Please consult your physician.

Under no circumstances should any action be taken based on these values without first discussing them with your physician/practitioner.

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Place Barcode Here

Medical Records Request and Release

PERSONAL INFORMATION

Patient Name			**Staff Use Only** □ Photo ID Verification
Date of Birth		Phone	
Date(s) of Service		Ordering Physician(s)	
Comments			

DELIVERY INSTRUCTIONS

☐ Mail	Address:
☐ Email	Address:
☐ Fax	Number:

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ACCESSION INFORMATION **(STAFF USE ONLY)**

Sample ID or Accession Number(s) (If additional space is required, attach list)			
Pathologist Authorization for Pathology Records if Applicable			

CONSENT

I hereby request Central Coast Pathology Laboratory (CCPL) to release copies of my laboratory results.

Signature of Patient or Legal Guardian (if minor): _____ Date: _____

Signature of Personal Representative: _____ Date: _____

*Must be accompanied by letter from patient giving authorization to release results to personal representative.

If I am a parent or legal guardian requesting access to minor's health records, I understand that I will not be provided access to records related to certain categories of results for example pertaining to pregnancy or STD's.

CCPL has the right to refuse this request.

STAFF USE ONLY

Employee Name/ID		Date		PSC	