MyDLSChart does not accept registrations for minors (under 18 years old).

Lab reports for minors (ages 13 and younger) can be requested via email by following the steps below.

All four (4) steps below must be completed to email test results. Email all items to help@mydlschart.com.

1. Fill in the attached form: Authorization for Use and Disclosure of Protected Health Information.

2. Complete the Authorization Statement below and email it with your request.

B. "I authorize Diagnostic Laboratory Services, Inc. to release laboratory test results for **(Place Minor's Last and First Name here)** to **(Place Guardian Last and First Name here)** via email."

3. E-mail a CLEAR photo of Parent/Guardian's valid identification

4. E-mail a SELFIE of the Parent/Guardian holding the same identification card that is used in step #3.

Below are examples of acceptable Identification Cards:

DIAGNOSTIC LABORATORY SERVICES, INC.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Laboratory Use Only: **Date:**
PSC: User ID _____, Loc # _____
(Attach copy of ID with form)
(Forward all forms to Client Services)
PSC Pick Up Location:

Client Services:
Date Received:
Patient ID Verified By:
Date Processed/Initials

I authorize Diagnostic Laboratory Services, Inc. to release the protected health information of: (* Indicates required field)

* Patient Name:_____ * Date of birth (MM/DD/YYYY): _____

* Address:_____ * City, State, Zip Code:_____/_____/ _____

* Phone #: _____ Email Address:_____

Mail To: *Name: _____

*Address:_____ * City, State, Zip Code:_____/_____/_____

*Date (s) of Service: _____ Extent or nature of information to be disclosed: ❑ All test results ❑ Specific test results: _____ Note: If you are requesting results before 2008 and/or for multiple dates of service a fee may apply ❑ Laboratory Requisition ❑ Other _____	Purpose for Use and/or Disclosure is "at the request of the individual", unless otherwise specified: ❑ Legal purposes ❑ Insurance ❑ Physician Follow-up ❑ Other _____

_____**(Initial) I agree to the release of alcohol and/or drug abuse related results. (If I do not specifically agree, this information will not be disclosed.)**

Unless otherwise revoked, this authorization will expire on the following date or event: _____.
If a date or event is not specified this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and Diagnostic Laboratory Services, Inc. will not condition or affect my ability to obtain services or payment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

I understand that I may revoke this authorization at any time by notifying Diagnostic Laboratory Services, Inc., Privacy Officer or the Client Services Department, in writing, of my revocation. This is described in the QHS Affiliated Covered Entity Notice of Privacy Practices. I understand that the revocation will not apply to any information that was already released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and no longer be protected under federal privacy regulations.

I hereby release Diagnostic Laboratory Services, Inc. from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings or recommendations as contained in the records released to or by Diagnostic Laboratory Services, Inc.

*Signature:_____ * _____
Patient or Personal Representative — Print Name

*Relationship:_____ * _____
(Relationship to Patient) * Complete only if requestor is not patient — Date

Please allow 1-2 days to process your request. Further clarification and/or validity of information provided may extend this time frame. In such cases, lab results will be withheld until all necessary information is verified. All requests will be kept on file and may be inquired upon if necessary.
Note: Requests made by a personal representative (someone other than the patient) will be reviewed by the DLS Compliance and Privacy Officer.