



I authorize Diagnostic Laboratory Services, Inc. to pre-register for access into myDLSchart.com for:

All fields are required unless otherwise noted.

Last Name: _____ Date of Birth (MM/DD/YYYY): _____ / _____ / _____

First Name: _____ Phone #: _____

Middle Name: _____ Email: _____

Street Address: _____ City/State/Zip Code: _____ / _____ / _____

Primary Physician: _____ Last Date of Service (MM/DD/YYYY): _____ / _____ / _____

(Not required, but recommended)

(Not required, but recommended)

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 except as allowed under federal privacy laws for: (i) research-related; 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 the Diagnostic Laboratory Services 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.

Initial _____ If I am unable to gain access to my results online, then this completed form acknowledges that DLS is able to mail a copy of my results to my address noted above when requested.

Signature: _____ Date _____

Patient or Personal Representative

Please allow 1-2 business days to process your request. You will receive an email with further instructions to activate your account once your request is processed. 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.

For Laboratory Use Only Client Services:

Date Received/By: _____

Patient ID Verified by: _____

Date Processed/Initials: _____