Reditus Laboratories, LLC
COVID-19 RECORD REQUEST
Consent to Release Laboratory Medical Records

Patient Information:

______________________________ Full Legal Name of Patient
______________________________ Patient Date of Birth (required)
______________________________ Maiden Name or Prior Name(s)
______________________________ Daytime Phone

Patient Address:

____
Street Address | City | State | Zip

Requesting Records FROM:

Reditus Laboratories, LLC ("Reditus")
Medical Records Dept.
1805 Riverway Dr. Suite A
Pekin, IL 61554

P: (866) 736-0002
F: (469) 498-0223

Release Records TO:

____
Name (IF **LEFT BLANK THIS WILL BE SAME AS PATIENT ABOVE)**

____
Street | City | State | Zip

______________________________ Telephone
______________________________ **Fax or email (REQUIRED)**

NOTE: Reditus is NOT responsible for unauthorized access to test records sent to you other than US mail. If you are using an UNENCRYPTED email, cell phone or fax that is not located in a secure area, you are solely responsible for any accidental or malicious access to this information.

Date/location specimen was obtained from patient: ______________________________
Date | Location

Specific Types of Information to be Disclosed:

☒ Lab ReportsCOVID-19

I understand the following:

a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties as required by law.

Any facsimile, copy or photocopy of this authorization shall authorize Reditus to release the records requested herein. Unless revoked in writing prior to disclosure, this authorization shall be in force and effect until two years from date of execution at which time this authorization shall expire.

Signed Authorization:

______________________________ Signature of Patient or Legally Authorized Representative*
______________________________ Date

______________________________ Print Name and Relationship of Legally Authorized Representative of Patient

______________________________ Witness
______________________________ Date

* Minor Patients (under age 18) and disabled persons require a parent or legal guardian to sign as legally authorized representative.