



**VERMONT DEPARTMENT OF HEALTH LABORATORY**

**359 SOUTH PARK DRIVE, COLCHESTER, VT 05446**

**FAX NUMBER: 802-338-4706**

**DEPARTMENT OF HEALTH**

**REQUEST FOR PATIENT RESULTS OR  
CORRECTIONS TO PATIENT RECORDS**

- This is a request for patient results. Test result requested: \_\_\_\_\_
- This is a request to change information in the patient's record.

Patient Last Name		Patient First Name	
Patient DOB	Patient Record Number	Date Specimen Collected	

<u>Error</u>	<u>Correction</u>

Please check box if you need an amended report faxed back when this information has been corrected.

Name of Practice, Clinic or Laboratory		Date
Printed Name	Signature	
Contact Phone Number	Fax Number	

**PLEASE FAX THIS FORM TO VERMONT DEPARTMENT OF HEALTH LABORATORY @ 802-338-4706**

**\*\* PLEASE MAKE COPIES OF THIS FORM FOR FUTURE REQUESTS OF RESULTS OR FOR MAKING CHANGES TO PATIENT RECORDS AT THE VERMONT DEPARTMENT OF HEALTH LABORATORY.**

**PLEASE CALL THE CUSTOMER SERVICES UNIT AT 802-338-4724 WITH QUESTIONS OR CONCERNS.**

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