



Release of Information Form		Fax to: (913) 341-6207	
Date:			
I, _____ authorize The Great Plains Laboratory, LLC to release medical information and/or test results to: (Print Name)			
Street Address:		City, State, Zip:	
Phone:		Fax:	
Email Address:			
Patient Name:		Date of Birth:	
Authorizing Physician Name (print):			
Authorizing Physician Signature (required):			
Patient / Guardian Name (print):			
Patient / Guardian Signature (required):			

**Fax this completed form to The Great Plains Laboratory, LLC (913) 341-6207.
For assistance, contact Customer Service by phone (913) 341-8949 or email CustomerService@GPL4U.com.**