Ottawa Regional Medical Center, Inc.

NOTIFICATION OF TEST RESULTS

Patient Name: **Date of Birth:**

Parent Name: _____

We make every effort to promptly inform you of your test results. In order to better serve you, please let us know how we may contact you with diagnostic testing results including laboratory, x-ray, and pap test reports.

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I authorize Ottawa Regional Medical Center staff to contact me by phone regarding test results:

Home: _____	Test results may be left on answering machine:	☐ Yes ☐ No
Cell: _____	Test results may be left on voice mail:	☐ Yes ☐ No
Work: _____	Test results may be left on answering machine:	☐ Yes ☐ No
Other: _____ (Phone Number & Identify Location)	Test results may be left on answering machine:	☐ Yes ☐ No

If I am not available to take your call, I authorize Ottawa Regional Medical Center staff to report my results (or my child's results) to:

Name: _____ (Print Clearly) Relationship: _____

Phone: _____

Name: _____ (Print Clearly) Relationship: _____

Phone: _____

Please notify our office of any changes to the above information as soon as possible.

_____ _____ _____ _____

Patient Signature Date Parent or Guardian Date