

ASSOCIATED PHYSICIANS OF SOUTHBURY  
TESTING RESULTS POLICY

PATIENT'S NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Due to increasing medical record technology, we make every effort to give you testing results in a timely manner.

Difficulties can occur with electronic interfacing of testing results, and we ask you to be proactive regarding your medical health.

For this reason we are asking you to sign the statement below:

I understand that whenever I have any type of testing done, if I do not get a response regarding the results within two weeks, it is my responsibility to contact the office.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_