The information on this form is collected under the authority of the Alberta *Health Information Act* and will be used only for the purpose of responding to your request for a COVID-19 result which is required for international travel.

**Submit completed form by:**

* Email to APLCIT@albertaprecisionlabs.ca
* Fax to 403-770-3701

**Fee:**

* **$25** online payment required
* Go to **AHS website > Information for > Patients & Families > Quick Reference > Make a Payment** or <https://www.albertahealthservices.ca/pay/Page11918.aspx>
* Routing number: **3003**
* Invoice number: **2020-001**

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| **Requestor Information** | [ ]  Mr. [ ]  Mrs. [ ]  Dr.[ ]  Ms. [ ]  Miss | Last name      | First name      |
| Mailing address      |
| City or town      | Province      | Postal code      |
| Telephone (business)      | Telephone (home)      | Email address      |
|  | Relationship to the patient/traveler: [ ]  Self [ ]  Other:      **Parent requestor:** initial here \_\_\_\_\_\_\_ to confirm there are no custody issues or court guardianship orders for the child.  |
| **Patient/Traveler****Information** | Last name [ ]  Same as above      | First name [ ]  Same as above      |
| Date of birth      | Personal Health Number      |
| **Request for COVID-19 result for international travel** | Date of collection  |       |
| Date of travel |       |
| Destination | [ ]  International [ ]  Domestic |
| **Delivery** | Results are routinely provided by email. [ ]  I require an alternate delivery method**By signing below the patient agrees to have their COVID-19 result emailed to the address indicated above.** |
| **Patient Signature** (Required) | Signature Date |

***For authorized office use only:***

|  |  |  |
| --- | --- | --- |
| Date received | ID confirmed: [ ]  Yes [ ]  N/A | Request number |
| Date released | Signature of recipient | Records released by |