Your Laboratory Guide to Good Health

NAME LAST FIRST

ADDRESS

CITY

STATE ZIP CODE

DATE OF BIRTH - -

SOC. SEC. NUMBER - -

To receive your results, please complete the upper portion of this form and then carefully read and sign the following notice. Please mail to the address listed below or fax to 913-492-8880.

I authorize Clinical Reference Laboratory to send my lab results (no HIV antibody or drugs of abuse results will be included) to me at the address above. I understand that this is an informational program only and is not a substitute for medical care. I understand that no medical diagnoses are being made and if I have any questions or concerns regarding my results or my health, I should consult my personal physician. This authorization is valid for up to 120 days after specimen collection.

Your Signature: _____ Date: _____

Please Mail to:

ATTN: INSURANCE RECEPTIONIST
CLINICAL REFERENCE LABORATORY
8433 QUIVIRA RD
LENEXA KS 62215-2802