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 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 62215-9823