

To: _____ **From:** _____

Attn: _____ **Date:** _____

Fax: _____ **Time:** _____

ADD / CANCEL TEST REQUEST FORM

Regarding our telephone conversation, please make the changes manually below.
Please print and sign your name; date and fax this back to 501.268.8337.
Your prompt assistance with this matter is greatly appreciated.

Patient Name: _____

Accession Number: _____

Please make the following changes:

Add:

Cancel:

By signing this form I agree and authorize the information listed above.

Signature

Print name

Date

CONFIDENTIALITY NOTICE: Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obliged to maintain it in a safe, secure and confidential manner. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Version 2 - 12/2/08

The Lab of Path, PA
1915 West Beebe Capps Expressway - Searcy, AR 72143
800.495.3332 (V)
501.268.8337 (F)

This facility is in compliance with Title VI of Civil Rights Act and does not discriminate on the basis of Race, Age, Sex, Color or National Origin.