



CLIENT AUTHORIZATION NAME DISCREPANCY

Facility Name: HealthTrackRx of Louisville

Date of Request: 01/24/24

Correct Patient Name: Demo HTRXTEST

Accession #: _____

Patient DOB: 01/01/2000

Date of Collection: 01/23/24

Name on Specimen: BLANK

Type of Specimen: RESPIRATORY

Accurate specimen identification is in the best of interest of the patient and you, or client. Laboratory regulations and good laboratory practice require proper identification of all specimens.

Please note that some results may not be reported until this documentation has been completed and received by the laboratory. Please fax completed form to: 940-295-1483

To be completed by Client

I AUTHORIZE THE RELEASE OF RESULTS AND AGREE TO ASSUME RESPONSIBILITY FOR SAMPLE IDENTIFICATION.

1/24/24

Signature of Physician/Clinician

Date

Must be printed or electronic, cannot be typed

Jane Doe

Printed Name of Physician/Clinician

..... **OR**

Authorized Facility Employee

Electronically Signed (must check when typing in name)

use for non-order information only

THE FOLLOWING INFORMATION WILL APPEAR ON THE REPORT:

Physician/Clinician name, the name of the sample, and the message "Sample received unlabeled or with a name discrepancy. The Physician/Clinician has authorized the release of the results. The Physician/Clinician agrees to assume responsibility of sample identification."