CLIENT AUTHORIZATION NAME DISCREPANCY

Facility Name: _____ **Date of Request:** _____

Correct Patient Name: _____ **Accession #:** _____

Patient DOB: _____ **Date of Collection:** _____

Name on Specimen: _____ **Type of Specimen:** _____

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.

_____ REQUIRED _____

Signature of Physician/Clinician **Date**
Must be printed or electronic, cannot be typed

_____

Printed Name of Physician/Clinician

. . . . . ***OR*** . . . . .

_____

Authorized Facility Employee
use for non-order information only

☐ **Electronically Signed (must check when typing in name)**

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."