1500 Interstate 35W
Denton, TX 76207
Phone: 940.383.2223
Web: HealthTrackRx.com

INSTRUCTIONS FOR FILLING OUT A CLIENT AUTHORIZATION FORM (CAF)

If you have any questions, please contact your Account Representative, or call HealthTrackRx Client Experience at 940-383-2223

Facility Name: 1 _____

Correct Patient Name: 2 _____

Patient DOB: 3 _____

Name on Specimen: 4 _____

Date of Request: 5 _____

Accession #: 6 _____

Date of Collection: 7 _____

Type of Specimen: 8 _____

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

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1 **Facility Name** ***(required)***
Clearly print the Facility the patient was seen at.

2 **Correct Patient Name** ***(Required)***
Clearly print the name of the correct patient, who the sample is intended for.

3 **Patient DOB** ***(required)***
Clearly print the DOB of the correct patient.

4 **Name on Specimen** ***(required)***
Clearly print the name of the patient on the specimen tube. If it is blank, clearly print “BLANK” on the line. If foreign barcode, but no name, put “BLANK”.

5 **Date of Request**
The date the CAF is being submitted.

6 **Accession #**
The SID, Sample Name, RID, or Order# the CAF is intended for.

7 **Date of Collection** ***(required)***
The date the sample was collected.

8 **Type of Sample** ***(required)***
The sample source; Urine, Wound, Nail etc.

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Either fill out A&B OR C&D, but always fill out E.

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

A

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

E REQUIRED

Date

B

Printed Name of Physician/Clinician

OR

C

Authorized Facility Employee
use for non-order information only

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

A **Signature of Physician/Clinician**
If the name of the physician/clinician is being placed in box "B", we MUST have a signature in box "A". The check box "D" ***does not*** apply to box "A". It can be a wet signature, with ink pen, or an electronic signature, like on a tablet, or signature applied through PDF program.

D **Electronically Signed**
This box must be checked if box "C" is electronically being filled out. This box ***only*** applies to box "C" and cannot be applied to box "B".

B **Printed name of Physician/Clinician**
The name of the Physician/Clinician. If filling out box "B", box "A" then MUST be signed. Box "D" ***does not*** apply to this box. The name can be printed with ink pen or typed electronically.

E **Date *(required)***
The date the Physician/Clinician or authorized facility employee has filled the CAF out. This is required no matter which section (A/B or C/D) is filled out.

C **Authorized Facility Employee**
If the Physician/Clinician is not the person filling out the CAF, but an authorized facility employee is, print the name of the employee either in ink pen or type electronically. Do not fill out boxes "A" or "B" if the physician/clinician does not intend to sign the form. **If box "C" is being done ELECTRONICALLY, box "D" MUST be checked.** If box "C" is handwritten, box "D" cannot be checked.