

Authorization for Add-On Testing

According to our records, a test was added to the original order for this patient based on verbal instructions. Please verify the accuracy of the following information, sign, date, and fax back to: **469.232.9927**.

In accordance with federal, state, and local statutes and regulations, including the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Health Insurance Portability and Accountability Act of 1996 (HIPAA), I/we understand that by signing this request, I/we will be responsible for the proper use and confidentiality of the health care information requested.

! Please be advised that any standing orders on file will not apply to add-on testing.

PATIENT NAME ↓	DATE OF BIRTH
ACCESSION NUMBER (IF AVAILABLE)	
TEST TO BE ADDED TO ORIGINAL ORDER	DX CODE
COLLECTION DATE	
HEALTHCARE PROVIDER NAME	
REQUESTOR NAME	PHONE NUMBER
REQUESTOR SIGNATURE	DATE
COMMENTS	

AVERO USE ONLY

TEST ORDER READ BACK & ACCEPTED BY ↓	DATE	TIME
AUTH REQUEST SENT BY	DATE FAXED	DATE RECEIVED
ACCESSIONED BY	DATE	TIME

**focused on
answers.**

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