Report Correction Request

Please complete and 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.

PATIENT NAME ⬇ | DATE OF BIRTH

ACCESSION NUMBER *(If available)*

COLLECTION DATE | TEST

HEALTHCARE PROVIDER NAME

REASON FOR CORRECTION

REQUESTOR NAME | PHONE NUMBER

REQUESTOR SIGNATURE | DATE

COMMENTS

AVERO USE ONLY

DATE ⬇ | TIME

CSR INITIALS

focused on **answers.**

6221 Riverside Drive, Suite 119
Irving, TX 75039
877.232.9924

3560 Meridian Street, Suite 101
Bellingham, WA 98225
360.527.4580

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