Specimen Release Form

Allele Diagnostics
120 N. Pine St, Suite 152
Spokane, WA 99202
Phone: 844-ALLELE2 (255-3532)
Fax: 509-232-5779
Email: info@allelediagnostics.com

Allele Diagnostics understands that specimens may need to be released to another clinical laboratory and can accommodate these requests with the completion of this authorization form. If desired, the health care provider can contact our laboratory at 844-ALLELE2 (255-3532) to discuss the availability of the specimen(s) to be released prior to completing and submitting this form. If the specimen release is being requested by the patient or legal guardian, a photocopy of a government-issued ID must also be included.

Sample Information

	Patient Full Name	Allele Diagnostics #	Sample Type Requested	Minimum Amount
Specimen 1	____________________	__________________	___________________	_______________
Specimen 2	____________________	__________________	___________________	_______________
Specimen 3*	____________________	__________________	___________________	_______________

*If the Health Care provider is requesting the release of more than 3 specimens at a time, a separate document, listing the full name, Allele Diagnostics #, sample type, and minimum amount needed for each specimen, may be attached to this form.

Shipping Location

The specimen(s) will be shipped to the location listed below.

Laboratory / Institution Name: ____ Attn: ________________________
Address: ____
City: ____ State: _____________________ Zip: ______________________
Telephone: _________________________________ Email: ____

Shipping Payment Information

Shipping Courier: _____________________ Account #: __________________________________

If paying shipping charges by credit card, please provide the following information:
Type of card: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express
Name (as it appears on the credit card): ____
Card Number: ________________________________ Exp. Date: __________________ CCV #: _______________

Allele Diagnostics is not responsible for samples lost or damaged in the shipping process. The cost of the shipment must be covered by the requesting Health Care provider or patient unless previously indicated by Allele Diagnostics.

Authorized Signature(s) for Release of Specimen

(Please complete either section A or B)

A. Health Care Provider Name (First, MI, Last): ________________________________ NPI#: ___________________
Institution / Practice: ____
Telephone: ____ Fax: ____

Authorized Health Care Provider: As an authorized health care provider, I request and authorize Allele Diagnostics to release the specimen(s) listed above to the location listed above. By signing below, I verify that I am an authorized health care provider and have obtained consent from the patient(s) and/or legal guardian(s) for the release of specimens.

Signature: ____ **Date:** _______________________
Signature of Authorized Health Care Provider

B. Patient or Legal Guardian Name (First, MI, Last): ____
Patient Name: ______________________________________ Relationship to patient: __________________________
Telephone: ____ Fax: ____

Authorized Signatory: As an Allele Diagnostics patient or guardian to the patient, I request and authorize Allele Diagnostics to release the specimen(s) listed above to the location listed above. By signing below, I verify that I am the patient or legal guardian to the patient and consent the release of specimens. I am including a photocopy of a government-issued ID to verify my identity.

Signature: ____ **Date:** _______________________
Signature of Patient or Legal Guardian

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