Test Revision 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 there are instances when ordered tests need to be changed, added, or cancelled and can accommodate these requests with the completion of this authorization form. If adding a test is desired, the health care provider can contact our laboratory at 844-ALLELE2 (255-3532) to discuss the availability of the specimen(s) for additional testing. If a test is cancelled for any reason, Allele Diagnostics requests this form be completed and sent back. Please send the completed form via fax at 509-232-5779 or via email at info@allelediagnostics.com.

Change of Ordered Test

Patient Full Name: _____ Patient Date of Birth: _____
Test Ordered: _____
Change Test To: _____

Add a Test to an Order

Patient Full Name: _____ Patient Date of Birth: _____
Additional Test to Order: _____

Cancellation of a Test

Patient Full Name: _____ Patient Date of Birth: _____
Test to Cancel: _____
Reason for Cancellation: _____

Authorized Signature(s) for Test Revision

Health Care Provider Name (First, MI, Last): _____
Institution / Practice: _____
Telephone: _____ Fax: _____

Authorized Health Care Provider: As an authorized health care provider, I request and authorize Allele Diagnostics to revise the test(s) 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 tests ordered.

Signature: _____ **Date:** _____
Signature of Authorized Health Care Provider