New Patient Registration Form

Name:

Address:

Phone:

E-mail:

Date of Birth:

Allergies: ☐ Yes ☐ No

Test to be performed:

Receive Results: ☐ Pick Up ☐ Email

Signature: Date:

Consent & Authorization

I authorize Secure Labs to collect specimens and coordinate testing.
I understand testing is performed by a third-party lab.

I accept responsibility for results interpretation and payment.
I consent to release of results via email, fax, or pickup.

I understand Secure Labs is not liable for interpretation of results.

☐ Initial

Signature: _____ Date: _____