Laboratory

Patient Demographic Sheet
Marshall County Health Department

(Please Print)

First Name:_____

Last Name:_____

Date of Birth:_____

Address:_____

City:_____

State:_____ Zip Code:_____

Phone Number:_____

Primary Care Physician_____

I hereby authorize Marshall County Health Department to collect lab specimens and to release those specimens and medical information to either LabCorp Corporation of America, Quests Diagnostics Lab, CDD lab or KDHE lab for testing (company utilized is dependent on my health insurance company). I agree to assume responsibility for payment for any lab services that are not covered by my healthcare insurance.

X_____ X_____ X_____

(Signature) (Date) (Time)

8/2022 ts