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PATIENT INFORMATION FOR LABORATORY TESTING

I give Dr. Julie Anne Winfield and staff members my permission to submit the following personal contact and insurance information if any specimens are ever submitted to a diagnostic or pathologic laboratory for evaluation and/or testing.

_____ _____
Patient/Guardian Signature Date

Patient Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone: (_____) _____ - _____

Date of Birth: ____ / ____ / ____ SSN _____ - _____ - _____ Gender: M F

Front Copy of Card Back Copy of Card