Affix Patient Label

Patient Name:________________Date of birth:___________

Diagnostic Use Authorization

Due to various insurance requirements, it is necessary for us to inform you of where your diagnostic test will be sent.

The tests may or may not be covered by your insurance plan. If you have any questions about your insurance coverage, please contact your insurance company prior to having these tests performed.

I acknowledge that all diagnostic specimens obtained in our office (ex: laboratory, pathology, cytology etc.) will be sent to Bronson Hospitals for processing.

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Patient Signature   Date