PHYSICIAN'S AUTOMATED LABORATORY, INC.
A Sonic Healthcare Company

CENTRAL COAST PATHOLOGY LABORATORY
A Sonic Healthcare Company

Fax Number Verification Form

Date: ___/___/___ Time: _____

To: _____

Phone: _____ Fax: _____

From: _____

Phone: _____ Fax: _____

Dear Patient:

Please verify your DOB, home address and phone number, and upon verification of information your report(s) will be sent to the fax number provided.

Date of Birth	
Home Address	
Phone Number	

I hereby certify the information above is correct and authorize the lab to fax results to the number provided on the original request.

_____ _____
Patient/Authorized Representative Date

The information contained in this facsimile communication is intended only for the use of the individual or entity named above and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If you are not the intended recipient or the employee or agent responsible for delivering this communication to the intended recipient, you are hereby notified that any use, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication by error, please immediately notify us by telephone (collect) and return this communication to us at the address below via the U.S. Postal Service. Thank you.

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