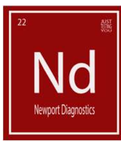

18242 W. McDurmott Suite C
Irvine, CA 92614

PHONE: 949.385.3535
FAX: 949.528.1313

PATIENT AUTHORIZATION FORM

Urine Drug Testing

Clinic Name:		
Address:		
Phone Number:		
Ref. Physician:		
PLAN NAME / INSURANCE COMPANY / CARRIER:		
ADDRESS	SUBSCRIBER NO.	GROUP NO.

Patient Name: ______________________________

Date of Birth: ____________ Age: ____________ Gender: ____________

Medical Record Number: ______________________ Phone: ____________

Clinical Information: ______________________________

Fasting: ☐ Yes ☐No

Specimen Type: Urine

Test Screen: Specimen validity and Urine Drug Screen
Test Confirmation: Comprehensive Urine Drug Confirmation LCMS

Specimen Validity:

AUTHORIZATION

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen cup is accurate. I authorize Biogene Diagnostics Laboratory to release the results of this testing to the requesting provider listed above. I hereby authorize my insurance benefits to be paid directly to Biogene Diagnostics Laboratory for services I received. I acknowledge the Biogene Diagnostics Laboratory may be an out-of-network facility with my insurance provider. I am also aware that in some circumstances my insurance provider will send the payment directly to me. I agree to endorse the insurance check and forward it to Biogene Diagnostics Laboratory within 30 days of receipt as payment towards Labs claim. I acknowledge that I am responsible for any amounts not covered by my insurer including any deductibles and co-payments/ co-insurance.

Patient Signature: ______________________ Date: ____________

Physician Signature: ______________________ Date: ____________