Athens Medical Testing

Direct Access Testing Consent Form

Name:_____
Address:_____
_____
_____

Social Security #: _____
Date of Birth: _____
Sex: _____
Phone Number: _____

Use the accompanying requisition form to indicate which tests you would like to have performed

Please indicate how you would like to receive your results:

- ☐A copy of your results will be mailed to you within a week.
- ☐You will pick up the results here at the laboratory
- ☐Fax results to this secure fax number:_____

Consent for treatment/payment:

This is to certify that I consent to and authorize the performance of specimen collection and analysis of the above marked laboratory tests. I understand that AMT is not acting as my doctor and that I have sole responsibility to take appropriate action on the test results and consult my doctor regarding all abnormal test results. I agree to take full financial responsibility for the cost of the tests that I request and that payment must be rendered prior to specimen collection. I understand that these tests will not be billed to a third party by AMT and no results will be sent to any physician or health care provider. I understand the cost of these tests may increase without prior notice.

Patient Signature: _____ Date: _____