A. PATIENT INFORMATION

First Name	Middle Name/Initial	Last Name

All Other Names (Nicknames, Alternate Spellings, Former Name, Etc.)

Address	Date of Birth (MM/DD/YYYY) / /

City	State	Zip	Phone Number

B. TEST ORDER INFORMATION

Ordering Healthcare Provider's Name (if known)

Approximate Date(s) of Service (MM/DD/YYYY) / /

C. REQUESTOR AUTHORIZATION

Print Name **By my signature below, I request that SkylineDx Laboratory provide a copy of the Laboratory Test Results to the location specified in Section D.**	Relationship to Patient: **If you are a legal guardian or representative of the patient, attach proof of representation as required (healthcare proxy, court order, power of attorney, etc.)** ☐ Legal Guardian (Provide Proof) ☐ Legal Representative (Provide Proof)
Signature	Date (MM/DD/YYYY) / /

D. DELIVERY INSTRUCTIONS FOR LABORATORY TEST RESULTS

Method of Delivery (Select one):

☐ Mail (USPS):			☐ E-mail (password protected):
Name (if different from above)			Email Address:
Address (if different from above)			
City	State	Zip	

E. SUBMIT FORM TO SKYLINEDX LABORATORY

Please submit this completed form and along with a picture of your government issued ID and any proof of representation, if required to:

SkylineDx Laboratory, LLC **OR** **Email: LabSanDiego@SkylineDx.com**
ATTN: CLIENT SERVICES
3030 Bunker Hill St. Ste 201
San Diego, CA, 92109

SkylineDx Laboratory will process the request within 30 days of receipt.

Internal Use Only

Date Received:	Accession #	Initials