

CONSENT FORM FOR THE RELEASE OF PATIENT INFORMATION

I _____ D.O.B _____ hereby give my

(Patient Name)

(Patient Date of Birth)

consent to the National Virus Reference Laboratory to release copies of the results for the following tests

(Test results required)

Signed: _____

(Patients Signature)

Witnessed: _____

(Doctor/Nurses Signature)

Please forward the results to

Clinician Name: _____

Address: _____
