QUALITY LABORATORY SERVICES

DIGITAL SIGNATURE CONSENT FORM

_____

CLIENT #

_____

PRACTICE NAME (if applicable)

_____

Street Address

_____

City State Zip Code

I, _____, provide my signature in the box below to Quality Laboratory Services who provides clinical diagnostic service and transfers results to me and my practice. I consent that my signature below may be electronically duplicated and used solely and exclusively on the online requests made by us, consistent with the services being provided to us and our patients by Quality Laboratory Services. I acknowledge that this is an accurate and true form of my signature.

_____ _____

Date Signed Phone Number

PLEASE SIGN IN BLACK INK, COMPLETELY WITHIN THE BOX.

Please Email to ApolloClinicalLabs@gmail.com

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