

Medical Liability Form



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|---------------------------------|------|
| Patient Name: | DOB: |
| City: | SSN: |
| Clinic Location: | |
| Lab Codes: | |
| Requesting Provider Name: | |
| Requesting Provider Fax Number: | |

I, _____ give CareATC® and Dr. _____
(Patient/Guardian) (CareATC® Physician)
("Physician") permission to draw blood on behalf of _____ ("Provider/Facility").
(Requesting Provider)

In addition, I acknowledge that CareATC® and its physician are drawing blood and running laboratory tests on Patient purely as a convenience for Patient and I release and forever discharge CareATC® and its physician from any and all liability to review such labs and consult with Patient regarding the results.

I further hereby authorize CareATC® to forward these results to _____ ("Requesting
(Requesting Provider)
Provider"). I assume all responsibility to follow up with the Requesting Provider to discuss the lab results and to develop a treatment plan.

Patient Signature (or Representative if Minor) Date

Relationship to Patient