PATIENT LAST NAME :	AddedByAgency2	REQUEST DATE :	2017-06-21
PATIENT FIRST NAME :	AgencyAdded2	CLINIC/AGENCY NAME :	future agency
DATE OF BIRTH :	1970-06-14	OFFICE NUMBER :	2
AGE :	47	FAX NUMBER :	9876543210
GENDER :	male	ADDRESS :	123 Sesame St,
PHONE NUMBER :	123456	CITY, STATE, ZIP CODE :	Manila,NY,654321
ADDRESS :		DOCTOR NAME :	Dr Future Agency
ADDRESS2 :		DOCTOR NPI NO. :	45612348973123
CITY, STATE, ZIP CODE :	Agency,AD,60452	DOCTOR/REPRESENTATIVE SIGNATURE :	
DIAGNOSIS (ICD 10) :			
SPECIAL INSTRUCION :	AgencyAdded2 patient detail		

☒**PT/INR**
☐**A1C**

I AUTHORIZE THE RELEASE OF MY INSURANCE CARRIER OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO TRUE LABORATORIES LLC.

PATIENT’S SIGNATURE	