Kansas

Susan Mosier, MD, Secretary | Department of Health & Environment | Sam Brownback, Governor

FAX AUTHORIZATION REQUEST

Facility Name _____
Facility Contact Person _____
Facility Phone Number _____
Facility Fax Number _____
KDHE Submission Form # _____
KDHE Staff Name _____

Date/Time _____
Patient Name _____
Date of Birth _____
MRN/HSN _____
Mother's Name _____
Other _____

Federal laboratory regulations require proper identification and complete demographic information on all specimens.

PLEASE COMPLETE OR VERIFY ONLY THE SELECTED MISSING INFORMATION:

☐ **Date of Birth** _____
☐ **Physician Name** _____
☐ **Test(s) Requested** _____
☐ **Patient Name** _____
Last Name **First Name**

☐ **Date of Collection** _____
☐ **Specimen Source** _____
☐ **Diagnosis Code** _____

Incorrect/Incomplete information if not listed below	Correct Information

☐ **Report Request** (one patient per fax) (specify test) _____
☐ **Add a Test** (one patient per fax) (specify test) _____
NOTES _____

I request the above mentioned report to be re-issued ***and/or*** I authorize the demographic correction/change/test addition and agree to assume responsibility. This information will be received verbally, however this document must be signed and faxed to the Kansas Health & Environmental Laboratories (KHEL) before final changes are made and final or amended reports issued.

_____ _____ _____
Printed Name (REQUIRED) **Signature (REQUIRED)** **Date**

Fax completed form and/or supporting documentation to:

☐ **Virology/Serology** (785) 296-1645
☐ **Diagnostic Microbiology** (785) 296-4880
☐ **Health Chemistry** (785) 296-0978

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