CONSOLIDATED MEDICAL BIO-ANALYSIS, INC.

11251 KNOTT AVENUE
CYPRESS, CA 90630
TEL: 714-657-7369; FAX: 714-657-7393

AUTHORIZATION LETTER

Date:

I, _____ of _____
(Manager/Doctor) (Name/Address of client/Institution)
_____, is hereby requesting and giving an authorization to (CMB) Consolidated Medical BioAnalysis, Inc., our contracted laboratory to print patient's confidential results (HIV Testing Results) through remote printing machine and/or fax machine.

Furthermore, I am aware of the Department of Health and State Law Regulation and Requirements that HIV test results are confidential and not to be re-released to anyone without signed authorization. On behalf of _____ (Patient), or check ___ for all patients, I release, Consolidated Medical BioAnalysis, Inc. from any responsibility that this decision may have caused

ACKNOWLEDGED BY:

_____
PRINT NAME (client designated office)

_____
SIGNATURE

_____
DATE

WITNESSED BY:

_____
PRINT NAME

_____
SIGNATURE

_____
DATE