Test Name (Please Circle):

MitoGen Mi-pMED3 ID-pMED3 A-pMED3 E-pMED3 AE-pMED3

Please name everyone in immediate family

Full Name	Relationship	Date of birth	Affected (yes or no circle)
	Self		Y N
			Y N
			Y N
			Y N
			Y N
			Y N

Insurance Company: _____ Provider Phone #_____

Primary Subscriber: _____ ID#_____

Insurance Type: PPO HMO Medicaid Medicare

Family Contact Information

Street Address: _____

City: _____State_____ and Zip Code: _____

Phone #:_____ Email Address: _____

I, _____, authorize this facility to run DNA testing. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to this facility. I authorize this facility to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. It is this facility's procedure to share Protected Health Information with labs, physicians, and hospitals. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature_____ Date_____