



Requester Last name: _____ First name: _____
DATE: _____

Fax Certification - New or Modification for primary fax for lab results:

Please indicate below what type of request is needed. Once the completed form is received by our lab, your fax number will be updated in our system. This certifies, we are sending patient information to the correct provider and/or submitting facility.

Please have the office manager or designated staff fill out the required fields in the space provided.

TYPE of Requests:

_____ *New Submitter or Provider - Primary Fax for lab results.*
_____ *Update Submitter or Provider - Primary Fax for lab results.*

Complete and fax back to Laboratory Fax (541) 706-7709. We cannot move forward with fax requests until this completed document is received back, Signed and Dated.

If you have questions or concerns about this process, please contact us at phone (541) 706-7717.
Thank you for your cooperation, to ensure timely and accurately delivered lab results.

Please fill out this form

I, Office Manager/Designated Staff, certify the following FAX numbers.

****Signed** _____ **Dated** _____

1. Print name of above individual:

2. FAX Number Being Certified:

3. Physician:

4. Name of Clinic:

Address:

Phone:

By completing this form, you will ensure patient confidentiality by verifying the fax number is in a secure area and out of public view as per Federal Regulations.

Lab use only:

Request completed Initials: _____