



EMPLOYER SOLUTIONS NATIONAL CLINICAL ACCOUNT

FOR QUEST DIAGNOSTICS USE ONLY – QUESTIONS PLEASE CALL 1.866.226.8046

Account Number	97518029
Account Name	Wellness First - AL
Address	4081 Hwy 14
City	Millbrook
State	AL
Zip	36054

SPECIMENS MUST
BE TESTED IN A QLS
LABORATORY

Collection Date	
Collection Time	

Ordering Physician and/or Payors	Physician Name	Marcial Mendez
UPIN	NPI	1407870504

PATIENT INFORMATION SECTION MUST BE COMPLETED PRIOR TO GOING TO LAB

CLIENT BILL
ONLY NO
PATIENT OR
THIRD PARTY
BILLING ON
THIS ACCOUNT

Patient Information	
Patient Name (first, last, middle)	
Date of Birth	(MM/DD/YYYY)
Patient ID#	
Patient Phone	
Street Address	
City	
State	Zip

Order Code	Test Name	Order Code	Test Name
X 483	Glucose	X 91695	Weight
X 7600	Lipid Panel	X 19689	Height
		X 91696	Blood Pressure
		X 16349	Waist Circumference

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize my health care providers, Wellness First and University Services staff and laboratories that run medical tests for me to use and disclose certain protected health information about me.

The protected health information will be used or disclosed for the sole purpose of complying with state and federal laws. These laws authorize a review and approve laboratory requisitions and review laboratory results.

I authorization my protected health information and laboratory test results to be mailed through the United States Postal Service in order for me, the patient , to receive results to allow me to make informed decisions about my health care.

I understand that I have to receive a copy of this authorization. I understand that I will not be able to receive laboratory testing unless I sign this authorization. I understand I have the right to refuse to sign this authorization. I understand that by signing this authorization I may not be continued to be protected under the HIPPA Privacy Rule. This authorization will expire one year after the date of this authorization.

I understand that this authorization is for my consent to participate in the AMGH Wellness performed by Wellness First and the parties listed above. I have received a copy of this authorization and consent to its terms and representations.

Name:

Signature:

Date:

This signed and dated authorization form must accompany your physician form and lab forms