Sovereign Health
Laboratory Services

Patient Acknowledgement and Consent Form

I understand that Laboratory is NOT a specimen banking facility and my sample will NOT be available after 60 days or future clinical studies. De-identified samples may be stored in a Repository and used internally for validation, educational, and/or research purposes OR presented in scientific presentations or papers. In addition, de-identified information may be submitted in a HIPAA-compliant manner to research databases.
It is my desire to opt out of participating in any research studies using my DNA sample.

Release and Consent
As a courtesy, Laboratory makes every reasonable effort to obtain reimbursement for ordered tests. I authorize Laboratory to release Medicare, its carriers, and any insurance carrier or health plan providing benefits to me, any information that may be needed for claim purpose. I am making an assignment of Medicare, Medicaid, and/or insurance benefits to Laboratory. I understand if my insurance company pays me directly for services rendered by Laboratory, I am responsible for forwarding such and all payments directly to Laboratory. I also understand and agree to that I am responsible for any copayment and/or deductible, as required by my plan.

IMPORTANT:
I have read and understand the Patient Acknowledgement and Consent as well as the Patient Disclosure on the back of this form. I permit a copy of this authorization to be used in lieu of the original.

Patient First Name:
Patient Last Name:
Date of Birth:
Facility:

Patient Signature: