Change In Testing Authorization (CITA) Form

Please complete the blank fields and fax back to **855.856.0655** or email form to **info@fulgentoncology.com**

Patient Information

LAST NAME | FIRST NAME

ACCESSION NO. | DATE OF BIRTH (MM/DD/YYYY)

Client Information

CLIENT | CLIENT ID (OPTIONAL)

Authorization

☐ I authorize Fulgent to **PERFORM** the following procedure(s):

☐ I authorize Fulgent to **CANCEL** the following procedure(s):

☐ I authorize Fulgent to return sample to submitting client

Return Address:

ATTENTION TO | PHONE

STREET ADDRESS

CITY | STATE | ZIP | COUNTRY

☐ I authorize Fulgent to dispose of sample

X _____ _____

PROVIDER SIGNATURE **DATE**

Disclaimer must be signed by authorizing Physician (or designee).

AUTHORIZED PHYSICIAN (PRINT NAME)

X _____ _____

SIGNATURE **DATE**

4207 E. Cotton Center Blvd., Phoenix, AZ 85040 | fulgentoncology.com | info@fulgentoncology.com | **Client Services** 1.888.354.8168 | **Billing** 1.888.FULGENT | **Fax** 1.855.856.0655