

Change In Testing Authorization (CITA) Form

Please complete the blank fields and fax back to **1.855.856.0655** 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)
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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
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Disclaimer must be signed by authorizing Physician (or designee).

AUTHORIZED PHYSICIAN (PRINT NAME)

X

SIGNATURE	DATE
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