CORPORATE OFFICE
115 Continuum Dr., Suite 2A
Syracuse, NY 13088
Tel: 315.461.3008
Fax: 315.461.3030

LABORATORY ALLIANCE
of Central New York, LLC
www.laboratoryalliance.com

OPERATIONS CENTER
113 Innovation Lane
Liverpool, NY 13088
Tel: 315.461.3008
Fax: 315.410.7007

AUTHORIZATION FOR CLINICAL LABORATORY TESTING

Location Code: UMC-_____

SUNY Upstate Medical University authorizes Laboratory Alliance of Central New York to perform the following tests on:

*Patient's Name: _____ *SUNY Accession #: _____

SSN: _____ *Date of Birth: _____

*Male/Female (circle one)

Call to: _____ *Fax to (circle one): 464-6733 464-8428

*Collection Date: _____ *Collection Time: _____

*Type of specimen:_____

*Provider Name: _____

*Testing to be performed at the expense of SUNY Upstate University Hospital:

1. _____
2. _____
3. _____
4. _____

*For Microbiology specimens, indicate source: _____

For Reportable Disease Testing, indicate patient county of residence: _____

*Authorized by: _____ Date: _____

Comments: _____

_____

_____

_____

This form must accompany any specimen submitted to Laboratory Alliance of Central New York from SUNY Upstate Medical University.

* Required fields