

**1 Facility Information**

\_\_\_\_\_  
Provider / Ordering Physician Name

\_\_\_\_\_  
Practice / Facility Name

\_\_\_\_\_  
Office Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email (for secure communication)

\_\_\_\_\_  
Fax (if applicable)

\_\_\_\_\_  
Office Hours (Days & Times)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2 Authorized Critical Value Contacts**

\_\_\_\_\_  
Primary Contact

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Backup Contact

\_\_\_\_\_  
Phone

\_\_\_\_\_  
After-Hours / On-Call Contact Name

\_\_\_\_\_  
After-Hours Phone Number

**3 Authorization**

I certify the above information is accurate and agree to notify the laboratory of any changes to ensure uninterrupted delivery of critical laboratory results

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Return Completed Form To: [accountmanagers@streamlinesci.com](mailto:accountmanagers@streamlinesci.com) or secure fax # 205-235-1258.