Date:

To: Alpha$_1$Center
1060 East 100 South
Suite 109
Salt Lake, City, UT 84102
Fax: 801-328-9166

In lieu of my signature on individual Alpha$_1$Center test requisitions, please consider this letter to be my authorization to test all samples submitted to your laboratory by my office for alpha$_1$-antitrypsin deficiency. This authorization will remain in effect through 12/31/19.

I have explained the risk and benefits of this genetic test, and the use to be made of the results, and I am confirming that the patient consents to be tested.

Sincerely,

_____

Physician's Signature

Physician's Name, Address, and Telephone Number:

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