Date: _____________

To: Alpha$_1$Center
1060 East 100 South
Suite 109
Salt Lake, City, UT 84102

Please consider this letter as my authorization to perform AAT deficiency testing per Alpha$_1$Center protocol on the enclosed patient blood samples collected as part of a Screening Day held at ___________________________ on _____________(Date). This letter is submitted in lieu of my signature on each individual test requisition.

I agree to accept the test results and distribute those results to the patient or the patient's primary care physician as necessary.

I understand it is my responsibility to ensure that the patient has been counseled regarding risks 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:

____
____
____
____
____