XPRESS URGENT CARE
WALK IN CLINIC

Permission to Test for Covid-19 PCR

Lab test requested by Zaid Noman, MD

Date: / / 2020

A. Patient's Information:

Name*: _____
LAST NAME FIRST NAME

Date of Birth*: _____ Birth Gender (check one) M ☐ F ☐
(MM/DD/YYYY)

Address*: _____City:_____ Zip_____

Phone Number: (_____) _____ email:_____

B. Testing will be billed to:

☐ **Insurance (attach one copy of your photo ID and medical insurance card (front and back)**

☐ **Paid by Employer or HRSA (attach a copy of your photo ID)**

C. Result will be sent directly to your email.

Printed Name: _____

Signature*: _____ **Date*:** _____