

# Familial Testing Sample Submission Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

How do you want your results sent to you? Email \_\_\_\_\_ Mail \_\_\_\_\_ Phone \_\_\_\_\_

Test for:

Paternity \_\_\_\_\_ Maternity \_\_\_\_\_ Other \_\_\_\_\_

Race of parent: \_\_\_\_\_ Race of child: \_\_\_\_\_

Gender of child: \_\_\_\_\_ Date collected: \_\_\_\_\_

Sample type: Buccal Swab \_\_\_\_\_ Other (additional fees may apply) \_\_\_\_\_

Has anyone being tested had a blood transfusion or stem cell transplant? If so, when? \_\_\_\_\_

Private Lab Results shall not be liable for any loss, or damage suffered by you or any other person as a result of the test results or lack thereof. You warrant that you are legally entitled to the possession of the samples you have provided to us. You agree to indemnify us against any loss or damage that we may suffer as a result of you providing us with the samples which have not been legally obtained. Results of the analysis is prepared for the use of the customer to whom it is given or sent. Results can only be released in accordance with the instructions provided by the customer on this document.

**Do not send any items in plastic bags.** Mail your samples to: **Private Lab Results, 8900 Viscount Blvd, AN 142, El Paso Texas 79925.** If you have any questions, please contact us at [info@privatelabresults.com](mailto:info@privatelabresults.com) or call 915-407-6224.

Signature of submitter: \_\_\_\_\_

Internal Use Only:

Date Rcvd \_\_\_\_\_ By \_\_\_\_\_ For Dept \_\_\_\_\_ IOC \_\_\_\_\_

