Authorization Form for Clinic Services

Employee Name:	Date:
Employee ID or SSN:	
Employer Name:	Phone:
Employer Contact:	E-Mail:
Address: City: St: Zip:	
SEND RESULTS: ☐Fax ☐USPS ☐ Email/www	Fax:

SERVICES REQUESTED	
☐ DOT Physical Exam	☐ Non DOT Physical
☐ Drug Test – Collection only. Donor to bring CCF Form	
☐ Breath Alcohol Test ☐ DOT ☐ NON DOT	☐
☐Drug Test	☐urine ☐ hair☐ oral fluid
☐ 5 panel ☐10 panel ☐	☐ rapid ☐ lab
Special Instructions:	

Service Authorized By (Employer Contact):
Employer signature:

Medical facility: Once this service is complete, please fax this authorization form back along with copies of all forms to InOut Labs at fax #: 847-410-8650

Third Party Administrator (TPA)/ All Billing and Questions:	
Contact:	**Phone:**
TPA Name:	**E-Mail:**
Address:	**Fax:**
City: State: Zip:	

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