



Test Cancellation Request Form

PLEASE CALL THE LAB FIRST! To cancel a test(s): (833)-4UNILAB

Date Requested: _____

Account name & #: _____

Person Requesting Cancellation: _____

(Signature)

Patient Name: _____
(Last Name) (First Name)

Patient DOB: _____

Date of Service: _____

Requested TEST(s) Cancelling: _____

Reason for Cancellation: _____

Please email the request to support@unilabhealth.com or Fax: 954-797-9494

*****Your signature confirms you are cancelling the tests specified above*****

NOTICE: The information contained in this transmission is privileged and confidential. It is for the use of the individual or entity named above. If the reader of this message is not the intended recipient, the reader is hereby notified that any consideration, dissemination, or duplication of this communication is strictly prohibited. If you have received this communication in error, please return this transmission to us at the above address by mail. In addition, please contact UNILAB immediately at 954-792-7422 to let us know that a communication error has occurred.