



**PATIENT INFORMATION SHEET / MISMATCH CORRECTION FORM**

**Account Number** \_\_\_\_\_

Account Name \_\_\_\_\_

Date of Service \_\_\_\_/\_\_\_\_/\_\_\_\_

Correct Patient Name \_\_\_\_\_  
(Please Print Clearly)

Name On Requisition \_\_\_\_\_

Correct Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth on Requisition \_\_\_\_/\_\_\_\_/\_\_\_\_

**This letter is to clarify and to request the above patient information to be corrected. By signing this letter, you give authority to Accu Reference Medical Lab to change and correct the above patient's information.**

\_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

(Physician or Authorized Personal Signature)