

CUSTOMER BLOOD TEST AUTHORIZATION FORM (please print)



Date Submitted: _____

I authorize (**insert name of retailer/health practitioner**) _____

to order the following selected blood test(s) through Life Extension®/National Diagnostics, Inc., on my behalf.

■ TEST CODE:	■ NAME OF TEST:	⋮	■ TEST CODE:	■ NAME OF TEST:
1. _____	_____		6. _____	_____
2. _____	_____		7. _____	_____
3. _____	_____		8. _____	_____
4. _____	_____		9. _____	_____
5. _____	_____		10. _____	_____

I understand that I will receive a requisition form for my blood to be drawn at any LabCorp Patient Service Facility (or a blood draw kit in lieu of the requisition forms, if applicable), and that I will receive results directly from Life Extension/National Diagnostics, Inc. Any and all contract/reference laboratories performing the tests will be fully disclosed. Any and all financial transactions will take place directly between me and the agent I have authorized to order these tests on my behalf. Purchase of these tests is based on the understanding that I am privately paying for these tests and there will be absolutely **no billing to Medicare, Medicaid or private insurance on my behalf.**

It is further understood that this blood testing facility is not responsible for the diagnosis or treatment related to any tests that are outside the normal range

of the reference laboratory. Tests outside the normal range may signal that you have a serious condition and need immediate medical attention and without the supervision of a physician there is a risk that you will ignore an abnormal test and that a treatable condition will get worse. You should see a physician if a test is abnormal, and if you do not, you assume all risks of injury that may result, and do hereby hold harmless and release, acquit and forever discharge all physicians rendering services related to obtaining and providing this blood test and the results for you, Medivo Services LLC, Life Extension Foundation Buyers Club Inc., Life Extension Foundation, Inc., National Diagnostics, Inc., and all of their officers, directors, agents, employees, and representatives, for any damages or injuries that might result from the drawing, transporting, and testing of your blood.

<p>Please check all of the following that apply:</p> <p><input type="checkbox"/> I will use a LabCorp blood draw station.</p> <p><input type="checkbox"/> I will not use a LabCorp facility and I require a blood draw kit.</p> <p><input type="checkbox"/> I am having my blood drawn in Massachusetts, New York, New Jersey, or Rhode Island. I require a blood draw kit so that I can get my blood drawn at any lab that draws blood (an additional local blood draw fee may be incurred).</p> <p><input type="checkbox"/> I am having my blood drawn AND I am ordering a frozen blood test that requires a cooler (additional charge applies, see reverse side for instructions).</p> <p><input type="checkbox"/> *I authorize Life Extension to send my test results directly to my health practitioner or Life Extension wholesaler who ordered the tests. E-mail or fax to: _____</p>	<p><input type="checkbox"/> *I authorize a Life Extension Health Advisor to review my results with me. Call me at _____</p> <p>Delivery Method:</p> <p>*I authorize Life Extension to send my blood test requisition to me via:</p> <p><input type="checkbox"/> E-mail _____</p> <p><input type="checkbox"/> Fax _____</p> <p><input type="checkbox"/> Standard shipping (via USPS First-Class Mail, no additional charge)</p> <p><input type="checkbox"/> UPS Overnight (add \$16)</p> <p><input type="checkbox"/> UPS 2nd Day (add \$7)</p>
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**When selecting viewing and delivery preferences please note that e-mail is not a totally secure method of communication.*

I have read and understand the shipping instructions for frozen tests as outlined on the reverse side of this form.

Customer Name (print): (First/Middle/Last) _____

Customer Address: _____

City/State/Zip-Postal Code: _____

SHIP TO Address: (If different from above) _____

City/State/Zip-Postal Code: _____

Phone: _____ **DOB:** _____ Male Female

Customer Signature Required: _____ **Date:** _____

This form must be completed and signed in order to process this order. If additional tests are requested, please complete another form.

FROZEN TEST INSTRUCTIONS

Customers who utilize a blood draw kit and purchase a blood test requiring that samples be sent to the laboratory on dry ice will receive a ThermoSafe Styrofoam cooler (an extra cost may apply) in which to ship the vials. **(These instructions DO NOT apply for customers going to LabCorp for the blood draw.)**

1. Up to 6 specimens can be shipped in the same Styrofoam cooler on 5 lbs of dry ice. Dry Ice **MUST** be used and cannot be substituted with a frozen cold pack or regular ice.
2. To locate a retail store for the purchase of dry ice 24/7:
 - a. Call Penguin Brand Dry Ice at 877-736-4846 for retail store information
 - b. Web information can be found at www.airgas.com
 1. Click on "Store Locator"
 2. Check the box which says "Penguin Brand Dry Ice Retailer"
 3. Enter your search criteria by zip code, city and state.
3. On the day you are having your blood drawn, you will need to purchase the dry ice as close as possible to the time of the blood draw. Simply place the dry ice in the cooler and proceed to the draw facility.
4. After the blood is drawn, the phlebotomist will centrifuge each specimen that needs to be frozen and transfer the specimen into a small plastic vial. The vials must be shipped on dry ice to Life Extension in Ft. Lauderdale, Florida, the same day they are collected (Monday – Thursday **only**). **Do not** ship on Friday, Saturday or Sunday or any other day before a public holiday.
5. All shipping labels and prepaid UPS waybills will be included with the cooler. Customers will not incur any additional shipping expense.
6. A full set of instructions regarding the blood draw, packaging and shipment of the frozen specimens will be included with the blood draw kit. Additionally, the blood draw kit will include all necessary blood drawing tubes and vials.