

*Henry Dorn, MD & Associates  
405 Lindsay Street  
High Point, NC 27262*

**Consent for Pathology Services**

**I have been informed that there may be a series of blood work or urine specimens collected for diagnostic purposes.**

**I consent to the medical care and treatment by Henry H Dorn, MD and Associates and agree to be responsible for the cost of such treatment and testing. All specimens are sent to Solstas Laboratory and I will be responsible for paying Solstas Laboratory directly for any amounts not covered by insurance.**

**Signature of Patient or Responsible Party** \_\_\_\_\_

**Date** \_\_\_\_\_