



**XPRESS URGENT CARE**  
WALK IN CLINIC

**Permission to Test for Covid-19 PCR**

Lab test requested by Zaid Noman, MD  
Diagnostic code : Z20.828

Date: \_\_\_\_\_

Name Of School District: \_\_\_\_\_

**A. PATIENT INFORMATION (NAME ON DRIVERS LICENSE): PLEASE PRINT NEATLY**

Name\*: \_\_\_\_\_  
LAST NAME FIRST NAME

Date of Birth\*: \_\_\_\_\_ Birth Gender M F  
(MM/DD/YYYY)

Address\*: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ PERSONAL email: \_\_\_\_\_

**B. Testing will be billed to:**

I have insurance through the school district  
(attach a copy of your photo ID and medical card—front and back)

I am not insured (attach a copy of your photo ID)--HRSA.

I have insurance but not through the district.  
(attach a copy of your photo ID and medical card—front and back)

*For office use only: Bill Client*

**C. Result will be sent directly to your personal email.**

Printed Name: \_\_\_\_\_

Signature\*: \_\_\_\_\_

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