



SARAPATH DIAGNOSTICS

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Authorization To Release Patient Information and Materials

Patient Name: _____
 Street: _____
 City: _____
 State _____ Zip: _____

MRN#: _____
 DOB: _____
 Phone: _____
 Other: _____

I authorize the release of the following health information (check below):

Pathology Reports Date(s): _____
 Pathology Slides Date(s): _____
 Pathology Blocks Date(s): _____
 Other _____

Who will release/disclose information:

Sender's Name: _____
 Sender's Address: _____
 City, St, Zip: _____
 Sender's Email: _____
 Sender's Phone: _____ Fax: _____

Who will receive information:

Recipient's Name: _____
 Recipient's Address: _____
 City, St, Zip: _____
 Recipient's Email: _____
 Recipient's Phone: _____ Fax: _____

Reason for release: Continuing Treatment Billing Other-list reason _____

This authorization is valid for six months from the date below or until _____ (date or event), not to exceed 24 months.

I understand that:

- By signing this form, I am authorizing release of protected health information for the reason as indicated above to all associated healthcare providers for treatment, billing or for other reason specified such as research or clinical trial.
- I am signing this form voluntarily. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I may revoke this authorization at any time by completing a "Request to Revoke an Authorization" form, which is available at SaraPath Diagnostic's Privacy Office. I understand that I may revoke this authorization except to the extent that action has been taken based on this authorization.
- If the receiving party is not subject to privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal/state law. SaraPath Diagnostics shall not be held liable for any consequences resulting from re-disclosure.
- I may request a copy of this signed form.
- SaraPath Diagnostics may charge an administrative fee to cover it's cost for express carrier delivery of patient materials. The amount of the fee will be _____ and is payable by check or credit card within 30 days of signing this form.

Patient or Legal Representative Signature

Date

If the patient is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

Print Legal Representative Name

Relationship to patient