SARAPATH DIAGNOSTICS

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Authorization To Release Patient Information and Materials

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ Phone: _____

State _____ Zip: _____ 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