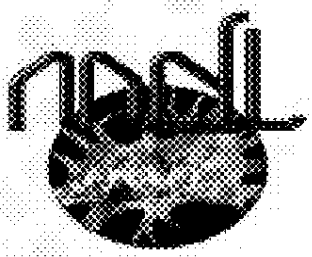

Medical Diagnostic Laboratories, L.L.C.
3439 Kuser Road • Hamilton, NJ 08690-3303 • 877.269.0099 • Fax: 609.570.1093 • www.mdlab.com

REQUEST FOR RELEASE OF ANATOMIC PATHOLOGY MATERIAL

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: (___) _____

REASON FOR REQUEST (CHECK ONE):

- ☐ Transfer of care to another institution or physician
- ☐ Patient requesting second opinion on pathologic diagnosis
- ☐ Physician requesting second opinion on pathologic diagnosis
- ☐ Physician, Pathologist, or designee requesting review of materials for pending surgery
- ☐ Other (specify) _____

Patient Authorization Form must be completed.

AT THE REQUEST OF:

Name: _____ Authorizing Signature: _____

Phone #: (___) _____ Fax #: (___) _____ Email: _____

RELEASE TO:

I authorize Medical Diagnostic Laboratories to release pathology results and materials on the above named patient to:

Physician/Facility: _____

Address: _____

City: _____ State: _____Zip Code: _____ Phone #: (___) _____

TYPE OF MATERIAL TO BE RELEASED:

- ☐ Cytology Slides/Reports: _____
- ☐ Pathology Slides/Reports: _____
- ☐ Other (specify): _____

PLEASE NOTE: There is a $30.00 processing and shipping fee for all requests; payment must be received prior to the slides release and we currently only accept credit card payments.

Payment method for delivery of slides/blocks:

☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Credit Card #: _____ Expiration Date: _____

Card Holder Name: _____ Signature: _____

By submitting this request, I assume full responsibility for the custody of the slides and/or tissue blocks, if received. The slides and tissue blocks are the property of MDL and must be returned within 14 business days using a prepaid return mailer which will be provided with the specimen.

Please fax completed form to (609)245-7671, Attn: Pathology Department

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PATIENT AUTHORIZATION FORM

I, _____ do hereby authorize Medical Diagnostic Laboratories, L.L.C. (MDL) to release my protected health information including copies of my medical record of services provided at MDL.

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Compliance Officer, or the Office Manager in my Doctor's Office. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under this policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by MDL.
- I understand that this authorization will automatically expire in 3 months unless otherwise specified.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ Date: _____

Print Name: _____

Relationship of representative to patient: _____

MDL Use only:
MDL #: _____
Number of H&E Slides: _____ Number of Blocks: _____ Number of Special Stains: _____
Number of IHC: _____ Number of Pathology Slides: _____
Date Slides Sent: _____ Initial: _____
Date of Return: Slides/Blocks _____ Report: _____