NYU HOSPITALS CENTER AUTHORIZATION FOR RELEASE OF PATHOLOGY MATERIAL

Lastname Firstname
MRN Sex DOB
ACCT Pt Type

Under federal and state law, we need your written permission before we share your protected health information (PHI), which includes your pathology material. Please read the information below carefully before signing this form. All fields must be completed.

Patient Name	Date of Birth	Phone Number
Address		

I, or my authorized representative, hereby give permission for NYU Langone Medical Center- Department of Pathology to share my pathology material. I understand that:

1. Information relating to **ALCOHOL/DRUG ABUSE, MENTAL HEALTH TREATMENT, GENETIC TESTING,** and/or **CONFIDENTIAL HIV-RELATED INFORMATION** will be shared if the pathology material includes this type of information. By signing this form, I specifically consent to the sharing of this information.
2. Except for HIV information, information that is shared because of this consent may be shared again by the recipient and no longer protected by federal or state law. Unless permitted by federal or state law, if I am giving permission to share HIV-related information, the recipient cannot share this information without my permission. I can ask for a list of people who may receive or use my HIV-related information without consent. If I experience discrimination because of the use or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I can withdraw my permission at any time by providing a written notice by fax to the Pathology Department at (212) 263-7916. This permission withdrawal will be effective except to the extent NYU Langone Medical Center has already relied upon this consent.
4. Signing this consent is voluntary. NYU Langone Medical Center may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this consent, except in limited situations.
5. I understand the pathology material I am requesting is original and cannot be replaced. I am releasing NYU Langone Medical Center from all responsibility for the maintenance of this pathology material.

Purpose for release of information:

Please explain: ______________________________

Description of information/material being released:

Date of Procedure: ______________ Accession Number (if known): ______________

☐ Pathology Slide(s) ______________________________

☐ Implant/foreign body ______________________________

☐ Pathology Report ______________________________

(Rev. 10/14)

MRN, Name, DOB: ____________

NYU HOSPITALS CENTER

Person receiving this information:

☐ Send to:

Name/Institution	Address Telephone Number: Fax Number (if applicable):

☐ I (or my personal representative) will pick it up and deliver to:

Name/Institution	Address Telephone Number: Fax Number (if applicable):

My personal representative (name): ____________________

(Identification required for pick-up)

Authorization will end in one (1) year unless the information is completed below:

☐ Specific event or date (specify): ____________________

All items on this form have been completed and my questions have been answered. In addition, I have been provided a copy of this form.

Signature: ____________________ Date: ________ Time: ________ AM/PM
(Patient or person authorized to sign)

If the consenting party is other than the patient, print name and relationship to patient. Supporting documents should be provided at the time of the request.

Name/Relationship: ____________________

Office Use Only: MRN: ____________ Received: ____/____/____ Initials: ________