UniPath
Palm Beach Pathology
Eastern Carolina Pathology

Patient Request/Release Consent Form

Phone: 303-512-2299 | 1-866-864-7284 (toll free)
Fax: 303-512-2252 | www.ap2.com

Patient Last Name: ______________________ First Name: ____________________ Last 4 Digits SSN: _______
(Optional)

Patient Address: ____ ______________ _________________
(State) *(Zip Code)*

Date of Birth: ______ /______ /________ Phone #: ______-_______-________ Request Date: ____________

Clinician/ Physician Name: ____________________________Group Practice Name: _________________________

Group Practice Address: ____ _______________ __________
(State) *(Zip Code)*

Specify Date(s) of Service: ___________________

Specify items requested:

☐ Slides Slide Number(s):______________________________

☐ Report(s)

☐ Tissue (Research) Fresh: ☐ Yes ☐ No If yes, specify specimen site:_____________________
(Above requires approval from Institutional Review Board or IRB)

How would you prefer the materials be delivered? ☐ Fax ☐ Mail ☐ Other _____________________

If by fax, please provide the fax number: ______________________________

If by mail, please provide the address: ____

If you are a patient requesting materials, a copy of your photo ID is required. ☐ *Attached?*
If you are a patient designee or patient representative, notarization is required. ☐ *Attached?*

I grant permission to release my medical records, tissue and/or slides and agree to release this laboratory, its physicians and employees from any claims, suits, damages or complications which may occur while in my custody.

__________________________________ ____________
Patient Signature Today's Date

__________________________________ ____________
Requesting Designee Signature Today's Date