Authorization for Release of Pathology Slides, Blocks and/or Reports

I, the undersigned, authorize Summit Health to release the requested material to the person(s) named below. This release is to be limited to the specified reports and/or dates of treatment I have indicated. I understand that this consent shall operate as a complete release of liability to Summit Health and its employees for the release of information specified.

Patient's Name: _____
Last First Middle

Home Address: _____

_____
City State Zip Code

Date of Birth: _____ **Phone #:**_____ **Email (optional):**_____

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is hereby authorized to release to:
Name: _____ **Organization:**_____
Full Address: _____
Phone: _____ **Fax:** _____

Material Requested: **Date(s) of Service:** _____ **Provider/Specialty:** _____

# of Slides Sent _____ **Accession #** _____
# of Blocks Sent _____ **Accession #** _____
# of Reports Sent _____ **Accession #** _____

As these slides/blocks are a part of the patient's medical record, it is requested that they be returned to Summit Health-Pathology Department with a copy of the consultation report. I understand this authorization may be revoked **in writing** to the **Summit Health Privacy Officer at 121 Chanlon Rd. New Providence, NJ 07974** at any time, except to the extent that action has already been taken in response to this authorization. This authorization will automatically expire **three (3) months from the date of signatures**. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I also understand that the information used or disclosed according to this authorization may be subject to redisclosure to a Third Party by the recipient and may no longer be protected. I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on my failure to sign this authorization. I have read and understand the terms of this agreement and have had an opportunity to ask questions about the use and disclosure of my health information.

Signature of Patient: _____ **Date:** _____
(If 18 years or older or is an emancipated minor)

Signature of ☐ Parent ☐ Legal Guardian _____ **Date:** _____
Note: If legal guardians checked, documentation establishing relationship must be provided.

Please send the completed form to:	**OFFICE USE ONLY**
Summit Health **Pathology Department** **Bensley Pavilion – Ground Fl.** **1 Diamond Hill Rd.** **Berkeley Heights, NJ 07922** **Fax: 908-464-3076**	**# of Slides/Blocks Sent:** _____ **Date Sent:** _____ **# of Slides/Blocks Returned:** _____ **Date Returned:** _____ **Pathologist Signature:** _____