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Patient Authorization for Release of Surgical Pathology Slide(s), Blocks, & Report

PATIENT INFORMATION

Patient's First Name _____

Patient's Last Name _____

DOB (MM/DD/YYYY) _____

Medical Record Number (MRN) _____

Phone _____

REQUESTED SPECIMEN DETAILS

Block / case #	Dates of service for the procedure	Unstained slides are being requested
		☐ yes ☐ no
		☐ yes ☐ no
		☐ yes ☐ no
		☐ yes ☐ no

SENDING FACILITY

Facility Name _____

Address _____

Phone _____

Fax _____

Email _____

RECEIVING FACILITY

Facility Name
Fulgent

Address
4401 Santa Anita Ave
Temple City, CA 91780

Phone
(888) 354-8168

Fax
(626) 454-1667

Email
clientservices@fulgentgenetics.com

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PURPOSE OF DISCLOSURE

PATIENT ACKNOWLEDGMENT

I authorize _____ (sending facility's name) and its employees to release my surgical pathology slide(s), blocks, and/or reports to Fulgent/ CSI Laboratories.

- I understand that this authorization extends to all information designated above, which may include diagnosis or treatment for a physical illness, including, without limitation, screening or diagnosis of genetic conditions or cancer.
- I expressly consent to the release of information designated above.
- I understand that I have the right to receive a copy of this authorization.
- I understand that the sending facility may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. This authorization is valid for 60 days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information.

Signature of Patient Or person authorized to consent, with power of attorney	**Relationship, if not the patient** **Date Signed**
Witness (Optional)	Date Signed

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