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

Patient Information

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH (MM/DD/YYYY) | MRN | PHONE

Requested Specimen Details

Block/Case #	Dates of service for the procedure	Unstained slide are being requested
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

Sending Facility

FACILITY NAME

ADDRESS LINE 1

ADDRESS LINE 2

CITY | STATE | ZIP

PHONE | FAX

EMAIL

Receiving Facility

Facility Name
Fulgent/Inform Diagnostics

Address
4207 E. Cotton Center Blvd.,
Phoenix, Arizona 85040

Phone
888.354.8168

Fax
855.856.0655

Email
clientservices@fulgentgenetics.com

Purpose of Disclosure

Patient Acknowledgement

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

- 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.

X _____ PATIENT SIGNATURE (Or person authorized to consent, with power of attorney) | RELATIONSHIP (If not the patient) | DATE (MM/DD/YYYY)

WITNESS (Optional) | DATE (MM/DD/YYYY)

