Pathology Reference Laboratory

Patient Information Release Form

This form must be completed and submitted with proof of identity. A copy of the patient's driver license (front and back) or other government issued ID must be submitted along with the form.

Please print clearly.

PATIENT INFORMATION:

Patient Full Name: _____ Patient DOB: _____

Other Names (maiden name, nickname, etc.): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Phone#: _____

INFORMATION TO BE RELEASED:

Please check all that apply: ☐ Pathology/Lab Report ☐ Slides and/or Blocks

Ordering Physician Name: _____

Date of Service (MM/DD/YYY). If unsure of Day, (MM/YYYY):_____

Note: If services were performed in a hospital, please contact the hospital directly.

WHERE TO SEND RECORDS:

Please check one:

☐ By Fax: _____ Requestor asserts the fax is secure.

☐ By Email: _____ Email will be password protected.

☐ By Mail: If different from the above address, please list below:

Attn: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Signature below authorizes Pathology Reference Laboratory to release pathology/laboratory records which include Protected Health Information (PHI) as requested.

SIGNATURE: _____ DATE: _____

Relationship to patient: ☐ Self (Patient) ☐ Legal Guardian ☐ Other Representative

Print Name: _____ If Other, describe: _____

Fax (210) 614-4659 or **Email** PatientBilling@pathreflab.com
or **Mail** to 9600 Datapoint Dr., San Antonio, TX 78229

Rcv'd Date:_____Date Sent: _____
Staff Person Sending: _____