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# Release of Medical Information Authorization

This is to certify that the undersigned gives full consent to Pinkus Dermatopathology Laboratory (PDL), an Aurora Diagnostics Partner, to release the following medical information via fax, US mail, UPS, Fed EX, Courier, or Hand Delivery.

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Patient SSN: \_\_\_\_\_

Pathology Number(s): \_\_\_\_\_ Dates of Service Requested: \_\_\_\_\_

**Information to be Disclosed** (check the appropriate boxes and include other information where indicated):

- Pathology Report Only
- Pathology Report and Pathology Slides
- Other: \_\_\_\_\_

**Reason for Medical Records Release:**     Continuation of Care     Personal Use

Requests are processed daily. Material is sent out within two business days of receiving a valid release (provided that the material is available). Material is sent using UPS ground. If you require alternative courier services, please note that here: \_\_\_\_\_

**Please forward the requested information to:**  
(Please include full address and phone number)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note:**

1. This authorization is only applicable for one year unless indicated otherwise.
2. The patient may revoke the authorization in writing.
3. Treatment is not conditioned upon the patient signing an authorization.
4. The recipient may re-disclose this information unless this box is checked.

Telephone Number: \_\_\_\_\_

Signature of Patient/Guardian/Referring Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

Date Requested Material Sent: \_\_\_\_\_

Pinkus Employee Initials: \_\_\_\_\_