



4path, Ltd.

Release of Diagnostic Material for Outside 2<sup>nd</sup> Opinion

Send Completed Form to: 4path, Ltd., 9050 W. 81st Street, Justice, IL 60458

or FAX to 708-929-4330 (toll free: 877-88-4path)

Please allow 3 working days from receipt of request for processing.

All materials are sent by commercial mail service with tracking.

Patient to complete. All information must be provided. Please print clearly

Patient Information

Patient Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth (M/D/Yr) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone FAX

Specimen/Procedure Information

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of procedure Physician performing procedure Procedure

Location where procedure was performed \_\_\_\_\_

Type of tissue to be reviewed or other information (and report numbers if available) \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone FAX

Reason for disclosure of information (i.e. 2<sup>nd</sup> opinion; Insurance request, etc)

Address of physician and/or institution receiving materials : \_\_\_\_\_

Name of Physician (REQUIRED) \_\_\_\_\_

Name of Institution or Hospital (REQUIRED). \_\_\_\_\_

Street Address (REQUIRED) \_\_\_\_\_ Suite \_\_\_\_\_

\_\_\_\_\_(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
City Zip Phone number (REQUIRED) FAX number

I authorize the 4path, Ltd. to disclose my personal health information and release slides, reports, and/or blocks to the above named physician and/or institution.

I agree that 4path, Ltd. will NOT be responsible for any charges that may be incurred from this second opinion examination and understand that 4path, Ltd. will not be responsible for any damage or loss of materials that they are not in possession of, once they are sent out and on loan to other sites, until they are returned. I understand that this release may include information relating to sexually transmitted diseases, AIDS, HIV or any other medical condition. I understand that I have a right to revoke this authorization at any time in writing to 4path, Ltd. at the above address or FAX number. I understand that the revocation will NOT apply to materials which have already been released in response to this authorization. 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. This authorization will expire 90 days from the date it is signed, unless I provide a different expiration date, in writing. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. Signing of this form allows for release of information from 4path, Ltd., but is not required to receive health care from 4path, Ltd. These materials are the property of 4path, Ltd. and are being released to serve the interest of the patient. I understand that I am responsible for the return of the materials within 14 days. If such materials are not returned, I agree to indemnify 4path, Ltd, and it's agents for payment of all claims, demands, settlements, or judgments, costs and expenses on account of or in any way growing out of 4path's inability to defend said claim, demand or lawsuit due to missing materials. This indemnification shall bind me, my heirs, legal representatives and assigns. I also understand that this will constitute an incomplete medical record, which may compromise my future care and/or treatment and I accept responsibility for any adverse outcome that may result due to the release of said materials.

Authorized signature \_\_\_\_\_ Date \_\_\_\_\_

For 4path use only:

Request Received: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Path Number(s): \_\_\_\_\_

Date Slides Sent Out: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ # Slides: \_\_\_\_\_ # Blocks: \_\_\_\_\_ ini: \_\_\_\_\_

Sent out via: \_\_\_\_\_ Tracking number: \_\_\_\_\_

Date Slides Returned: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ # Slides: \_\_\_\_\_ Damaged Y N # Blocks \_\_\_\_\_ ini: \_\_\_\_\_