



4path, Ltd.  
 9050 W. 81<sup>st</sup> Street  
 Justice, IL 60458  
 877-88-4PATH (Local: 708-929-4326)

CLIENT NAME: \_\_\_\_\_

**Release of Diagnostic Material to 4path  
 for Consultative Review**

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 E-mail \_\_\_\_\_

**Insurance Information**

\_\_\_\_\_  
 Company Name Group # Policy # \_\_\_\_\_

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

\_\_\_\_\_  
 Guarantor Relationship to Patient Social Security Number \_\_\_\_\_

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

Please provide the name of the physician you wish to receive a copy of this consultation report:

\_\_\_\_\_  
 Name of Physician to receive report Physician Phone number (\_\_\_\_\_) Physician FAX number (\_\_\_\_\_) \_\_\_\_\_

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

**Specimen/Procedure Information and Release**

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

Type of tissue to be reviewed or other information \_\_\_\_\_

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

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

I authorize the above institution to release all slides, reports, and blocks (as requested by 4path) to 4path, Ltd., 9050 W. 81st Street, Justice, IL 60458 1-877-88-4path (Local: 708-929-4326, Fax: 708-929-4330)  
 I understand that I will be responsible for any charges that may be incurred from this second opinion examination, even if not covered by my insurance company.

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

**For 4path use only**

Request Received: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Surgical Path Number: \_\_\_\_\_

Originating Laboratory contacted: \_\_\_\_\_

Date Slides Received: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ # Slides: \_\_\_\_\_ Damaged Y N # Blocks: \_\_\_\_\_

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