



Authorization for Release of Pathology Slides, Blocks and/or Reports

I, the undersigned, authorize Summit Medical Group ("SMG") to release the requested material to the person(s) named below. This release is to be limited to the specified reports and/or dates of treatment I have indicated. I understand that this consent shall operate as a complete release of liability to SMG and its employees for the release of information specified.

Patient's Name: _____
Last First Middle

Home Address: _____
City State Zip Code

Date of Birth: _____ Phone #: _____ Email (optional): _____

is hereby authorized to release to:
Name: _____ Organization: _____
Full Address: _____
Phone: _____ Fax: _____

Material Requested: _____ Date(s) of Service: _____ Provider/Specialty: _____

of Slides Sent _____ Accession # _____
of Blocks Sent _____ Accession # _____
of Reports Sent _____ Accession # _____

As these slides/blocks are a part of the patient's medical record, it is requested that they be returned to SMG-Pathology Department with a copy of the consultation report. I understand this authorization may be revoked **in writing** to the **SMG Privacy Officer at 121 Chanlon Rd. New Providence, NJ 07974** at any time, except to the extent that action has already been taken in response to this authorization. This authorization will automatically expire **three (3) months from the date of signatures**. 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. I also understand that the information used or disclosed according to this authorization may be subject to redisclosure to a Third Party by the recipient and may no longer be protected. I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on my failure to sign this authorization. I have read and understand the terms of this agreement and have had an opportunity to ask questions about the use and disclosure of my health information.

Signature of Patient: _____ Date: _____
(If 18 years or older or is an emancipated minor)

Signature of Parent Legal Guardian _____ Date: _____
Note: If legal guardians checked, documentation establishing relationship must be provided.

<p>Please send the completed form to:</p> <p>Summit Medical Group Pathology Department Bensley Pavilion – Ground Fl. 1 Diamond Hill Rd. Berkeley Heights, NJ 07922 Ph: 908-277-8699 Fax: 908-464-3076</p>	<p style="text-align: center;">OFFICE USE ONLY</p> <p># of Slides/Blocks Sent: _____ Date Sent: _____ # of Slides/Blocks Returned: _____ Date Returned: _____ Pathologist Signature: _____</p>
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