RML
REGIONAL MEDICAL LABORATORY

Slide Request
Regional Medical Laboratory, (RML)
Authorization for Release of Medical Information

Date of Request: ___________________ Request Taken By: ___________________________

Request Made By: ______________________ of _____________________________________
Physician name, Hospital or Clinic name

Requestor Phone #: ____________________ Requestor Fax #: _________________________

Patient Name: ___________________________ Accession #: ___________________________

Date of Birth: _____________________ Social Security #: ______________________________

I authorize RML to release patient specimen to:

Name: ______________________________________

Address 1: __________________________________

Address 2: __________________________________

City, State and Zip: ___________________________

Phone #: ____________________________________

____
Type of delivery & acct # if provided

Please check your request below:

Reports __________ Glass Slides __________ Tissue Blocks __________

I understand that this information will be used for the following purpose: (check all that apply)

____ To develop a diagnosis and treatment plan

____ To coordinate medical, psychological & social rehabilitative process

____ Other (Specify) ____

RML is authorized to furnish this information even though the confidentiality of the information may be protected by Federal and/or State laws and regulations.

This authorization expires 90 days from the below date and covers only treatment prior to that date.

______________________________________ ______________________________
Signature of patient or Patient's Physician Date of Signature

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For INTERNAL use only:

RML Pathologist: My signature indicates I have reviewed the case and have selected the appropriate slides to be released.

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RML Pathologist Signature