PSI
PATHOLOGY
SERVICES
INC.

Authorization for Release of Medical Records and Materials

Pathology Services Inc.
3017 Telegraph Ave. Suite 100
Berkeley, CA 64705
Phone 510-606-8787
Fax 510-644-2067

Patient Information	**Consulting Physician Information**
Name	Name
Date of Birth	Facility
Address	Department
	Address
City State Zip Code	
Daytime Phone	City State Zip Code
Evening Phone	Phone
Other	Contact Person

Records will be shipped or available for pick-up usually within 72 hours after receipt of ALL of the following, and could be available sooner if material is recent and stored on site:

- Completed Authorization for Release of Medical Records and Materials (this form)
- Acknowledgement of Receipt of Notice of Privacy Practices
- Copy of Current Insurance Card(s)

Please check one

☐ Please call me when my Medical Records/Materials are ready, I will pick them up.

☐ I request my Medical Records/Materials be sent by FedEx to the consulting physician listed above. Please apply the charge to my credit card number below:

Card #_____ Expiration _____

The following reports and materials will be sent;

_____

_____

_____

Page 2 Authorization for Release of Records and Materials

I hereby authorize Pathology Services Inc. to release my slides, blocks, and records. I understand that the materials are the originals and that the materials cannot be repaired, replaced, copied, or duplicated. I will take responsibility to ensure that either my treating physician or myself will return the materials. I indemnify Pathology Services Inc. of any responsibility related to the damage, loss or destruction of the material once it is removed from the PSI premises.

Your insurance is billed as a courtesy to you however; it is your responsibility to follow up with your insurance to make sure the claim is paid in a timely manner. We will submit a claim for secondary insurances after receipt of your primary insurance. Patient is ultimately responsible for paying for services if the insurance doesn't pay all or some of the charges and they are not otherwise adjusted off the bill.

Patient Signature _____ **Date** _____

This section to be completed at the time of shipment of the records or materials

☐ **Authorization received** ☐ **Acknowledgement received** ☐ **Insurance copies received**

Records Released by: _____ **Date** _____

FedEx Tracking Number _____

Other Tracking Information _____

Additional Information _____

Additional Information or Comments

_____

_____

_____

_____

PSI
PATHOLOGY
SERVICES
INC.

ANATOMIC PATHOLOGY-CYTOPATHOLOGY-DERMATOPATHOLOGY-IMMUNO/HISTOLOGY

PATIENT AUTHORIZATION FOR TESTING TO BE PERFORMED AT _____
(Reference laboratory Name)

Patient name: _____ DOB: _____ MRN:_____

We have been asked by your physician to send block(s) or unstained slides from the procedure performed on: _____ at Pathology Services, Inc. to:
(date of procedure)

_____

_____

_____
(Reference Laboratory Name and Address performing the testing)

In order to for us to complete this request and comply with HIPAA regulations, we need your authorization. Please be aware that performing the requested test(s) may exhaust all of your tissue, thereby preventing any additional tests/studies in the future.

_____ I authorize Pathology Services, Inc. to release my block(s) or unstained slide(s) and report. I understand that tissue in these block(s) may be exhausted in performance of this testing and may not be available for additional testing in the future.
(initial)

_____ On your behalf, the reference lab stated above will bill your insurance company for their professional services. You will be responsible for any contracted copay or deductible payment per your agreement with your insurance company. In the event that your insurance company or HMO denies payment to the designated reference lab, despite their arbitration on your behalf, the above reference lab will then send the bill to Pathology Services, Inc., who reserves the right to bill you directly for the services rendered.
(initial)

By signing below, you agree to accept full financial responsibility as a patient who is receiving services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____	_____	_____
Patient Signature	Date of Birth	Date
_____	_____	_____
Representative Signature	Relationship	Date

Please fax the signed form to (510) 644-2067 or email: office@psiberkeley.com

3017 TELEGRAPH AVENUE, SUITE 100 BERKELEY, CA 94705 — TELEPHONE: 510-644-9051 — FACSIMILE: 510-644-2067