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SLIDE/BLOCK RELEASE/CONSENT FORM

Patient's Name: _____

DOB: _____ Telephone #: _____

Reason for Release: ☐ Surgery ☐ 2nd Opinion ☐ Other: _____

Case # (s): _____

Slides (Stained): _____ Slides (Unstained): _____ Blocks: _____

Reviewing Pathologist: _____

Loaned To:

Physician/Facility: _____

Address: _____

Telephone #: _____

Date Mailed: _____ Hand Carried: _____

Please be advised that all slides/blocks sent to you in consultation or for review are the property of Crystal Run Healthcare. The materials are sent as a courtesy and **MUST** be returned to us as soon as you have completed your studies. These slides/blocks constitute an indispensable part of the patient's permanent record and must be maintained in our files for medical/legal purposes.

PLEASE RETURN THE MATERIAL(S) PROMPTLY ALONG WITH A COPY OF YOUR PATHOLOGY REPORT TO:

Crystal Run Healthcare
HIM Department
155 Crystal Run Road
Middletown, NY 10941
Telephone: 845-703-6999

This is a private consultation at the patient's request, and all billing should be directed to the referenced patient. Thank you. I hereby authorize and request Crystal Run Healthcare to release any Surgical/Cytology/Consultative report(s) and/or slide(s), block(s) to the physician/facility indicated.

Patient: _____

Witness: _____

Date: _____