PLA
Pathology Laboratory Associates

Slide Request
Pathology Laboratory Associates (PLA)
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 PLA 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) _____

PLA 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:

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

_____
PLA Pathologist Signature