



PRECISION ASPIRATION and BIOPSY
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<input type="checkbox"/> Treatment/ Consultation	<input type="checkbox"/> Patient request	<input type="checkbox"/> Outside Hospital	<input type="checkbox"/> Pathologist	<input type="checkbox"/> Attorney	<input type="checkbox"/> Physician
PATIENT INFORMATION			DESTINATION FOR / SOURCE OF PHI		
Patient Name			Institution/Physician		
Medical Record/Patient ID number			Street Address		
Street Address (if needed)			Attention to: Room Number		
City, State, Zip			City, State, Zip		
Telephone			Telephone Number		
			Contact Person		

Materials Requested by Precision Aspiration and Biopsy:

Case Acct. #	Report Only	Blocks	Slides	Other/Diagnosis

Materials to be sent out: Pathologist Authorization: _____ **Date:** _____

Case Acct. #	Total Blocks	Number Recut	Total Slides	# Slides Released

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

Patients Rights: I may refuse to sign this authorization and neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I have a right to a copy of this authorization.

California Law: California law prohibits Precision Aspiration and Biopsy from making further disclosure of my health information unless Precision Aspiration and Biopsy obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

Signature of Patient or Personal Representative Who May Request Disclosure

I can inspect or copy the protected health information to be used or disclosed. I authorize Precision Aspiration and Biopsy to use and disclose the protected health information specified above.

Signature: _____ Date: _____ Authority to sign if not patient

Identity of requestor verified via: Photo ID Matching signature Other: _____

Verified by: _____ Date: _____