Department of Pathology
3355 Douglas Road, South Bend, IN 46635
Phone 574-234-4176
www.sbmf.org/downloads

FAX COMPLETED FORM TO: (574) 807-3162

PATHOLOGY CONSULTATION AND RELEASE OF INFORMATION

All information must be completed before sample can be Processed. Please type or print.

PATIENT INFORMATION

Last Name: ______________________________

First Name: ______________________ MI: ______

Gender: ☐ Male ☐ Female Date of Birth (mm/dd/yyyy) __________

Address: ______________________________

City: ______________ State: _____ Zip Code: ______

Phone: ______________________________

ORDERING PHYSICIAN INFORMATION

Client/Institution Name: ______________________________

Ordering Physician: ______________________________

NPI #: ______________________________

Address: ______________________________

City: ______________ State: _____ ZIP Code: ______

Phone: ______________ Fax: ______________

Additional fax to: ______________________________

BILLING INFORMATION

Medical Necessity Notice:
Please be aware that insurance companies may require a determination of medical necessity before approving coverage for the release of pathology slides and reports. If insurance denies payment, the patient or requestor may be responsible for the full cost of services rendered.

BILL TO: ☐ Client/Institution ☐ Insurance ☐ Patient

Please attach complete demographic and insurance information.

Primary Insurance: ______________________

Secondary Insurance: ______________________

ICD-10 Code: ______________________________

Clinical History: ______________________________

Place of Service: ☐ Non-Hospital ☐ Outpatient

☐ Inpatient Discharge Date: __________

SAMPLE/SPECIMEN INFORMATION

Purpose for Release: ☐ Continuation of care ☐ Second Opinion Consultation ☐ Other

Accession #: ______________ Date of Collection: ____________ Bodysite: ______________ ☐ Slides ☐ Blocks

Accession #: ______________ Date of Collection: ____________ Bodysite: ______________ ☐ Slides ☐ Blocks

Accession #: ______________ Date of Collection: ____________ Bodysite: ______________ ☐ Slides ☐ Blocks

WHERE TO SEND PATHOLOGY MATERIAL

Recipient Name: ______________________ Organization/Facility Name: ______________________

Address: ______________________ City: ______________ State: _____ Zip Code: ________

Phone Number: ______________________ Fax Number: ______________________

Requestor's FedEx Account Number*: ______________________

***A valid account number or shipping label is required to ship material as SBMF does not assume responsibility for shipping costs. If you are unable to provide a valid account number or label, please select from the available options below or contact our office at (574) 234-4176 to discuss alternative arrangements.**

Bill to Patient Options:

☐ **(38056) $25.00 ------- Slide Retrieval**

☐ **(38407) $50.00 ------- Slide Retrieval and Shipping**

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form.

  Please indicate your legal authority and include documentation of your relationship:

  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.

Please indicate your relationship: ☐ Parent ☐ Legal Guardian

AUTHORIZATION

I hereby authorize South Bend Medical Foundation to release the information specified above to the requestor listed. I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the date of signature unless otherwise specified.

I understand that the information released may include information related to HIV/AIDS, sexually transmitted infections, behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that South Bend Medical Foundation cannot guarantee that the recipient will not re-disclose this information to a third party. The recipient may not be subject to federal privacy protections.

Signature of Patient or Legal Guardian: ____________________________

Printed Name: ____

Date: ____