4351 Tamiami Trail N
Naples FL 34103
Phone: 239-263-1777
Fax: 239-263-6983

NAPLES PATHOLOGY ASSOCIATES

Accession numbers:

_____

_____

_____

MEDICAL MATERIALS RELEASE AUTHORIZATION

I hereby authorize and request Naples Pathology Associates to release any and all Protected Health Information (PHI) concerning any of my illnesses and medical care, including pathology slides, diagnostic reports and/or applicable medical records during the period from:

_____ to _____. Reason for disclosure: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Soc Sec # _____

_____ Phone # _____

SEND RECORDS / PATIENT PICKUP / SEND REPORT TO PATIENT

Name of Facility: _____

Attn: _____

Address: _____

_____

Phone #:_____ Fax # _____

I understand and acknowledge that certain information which may be contained in the medical record requires specific authorization for disclosure, and except as otherwise provided by law such information may not be disclosed without my specific consent. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information could include: (1) alcohol /drug abuse, and/or (2) HIV testing and/or results.

I do hereby agree to release, indemnify, and hold harmless, Naples Pathology Associates, its officers, directors, employees, agents and medical staff, from and against any claims against or liability incurred by it at any time, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent. Signing this authorization may cause the PHI used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

AN ENLARGED COPY OF YOUR DRIVERS LICENSE IS REQUIRED.