MicroPath LABORATORIES

Request for Reprint of Patient Report

Send Completed Form to: MicroPath Laboratories, 1125 Bartow Road, Suite 101
Lakeland, FL 33801 or FAX to (863) 687-0742.
Please allow for 7 working days from receipt of request for processing.
All reports are sent by standard 1st class mail.

INSTRUCTIONS:
PLEASE READ CAREFULLY. INCOMPLETE SUBMISSIONS WILL NOT BE PROCESSED.
THIS FORM IS FOR REPORT REPRINTS ONLY. DO NOT USE FOR 2ND OPINION REQUESTS

1. Complete ALL information in the box below.
2. A photocopy of both sides (front and back) of the patient's (or authorized agent's) driver's license or other government issued PHOTO identification ("ID") is required to ensure identity of requestor. ID address must match the address to which the report is sent, for authentication purposes.
3. Sign and date under "authorized signature."
4. Reprints are sent ONLY to patient or authorized agent. No second party mailings are provided.

*******Incomplete submissions will not be processed.*******

Patient Information and Address for Report Delivery

Patient Name:_____ Social Security Number:_____-___-_____ Date of Birth: ____/____/____

Street Address:_____ City:_____ State:_____ Zip:_____

Phone: (_____) _____

Specimen/Procedure Information

Date of Procedure:____/____/____ Physician performing procedure: _____

Location where procedure was performed: _____

Report numbers (if available): _____

I authorize MicroPath Laboratories, Inc. to disclose my personal health information and release a report copy to the above individual at the address provided above.

I understand that this release may include information relating to sexually transmitted diseases or any other medical condition. I understand that I have the right to revoke this authorization at any time in writing to MicroPath Laboratories, Inc. at the above address or FAX number. I understand that the revocation will NOT apply to materials which have already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The authorization will expire in 90 days from the date it is signed, unless I provide a different expiration date, in writing. I understand that once the information is disclosed, it may re-disclosed by the recipient and the information protected by federal privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. Signing of this form allows for release of information from MicroPath Laboratories, Inc., but is not required to receive health care from MicroPath Laboratories, Inc. These materials are property of MicroPath Laboratories, Inc. and are being released to serve the interest of the patient. I understand that I am responsible for the return of any materials within 14 days (such as slides, blocks, or other materials which may be provided. Reprinted reports do not need to be returned). If such materials are not returned, I agree to indemnify MicroPath Laboratories, Inc. and it's agents for payment of all claims, demands, settlement, or judgements, costs and expenses on account of or in any way growing out of MicroPath Laboratories, Inc.'s inability to defend said claim, demand or lawsuit due to missing materials. This indemnification shall bind me, my heirs, legal representatives and assigns. I also understand that this will constitute an incomplete medical record, which my compromise my future care and/or treatment and I accept responsibility of any adverse outcome that may result due to the release of said materials.

Authorized Signature: _____ Date: _____

For MicroPath use only: Request Received: ____-____-____ Accession Number(s):_____

Date Sent Out: ____-____-____