MID-ATLANTIC
PATHOLOGY SERVICES, INC.
An Aurora Diagnostics Partner

Release of Medical Information Authorization

This is to certify that the undersigned gives full consent to Mid-Atlantic Pathology Services, Inc, an Aurora Diagnostics Partner, to release the following medical information via fax, US mail, UPS, Fed EX, Courier, or Hand Delivery.

Patient Name: _____ Patient's Date of Birth: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Patient SSN: _____

Pathology Number(s): _____ Dates of Service Requested: _____

Information to be Disclosed *(check the appropriate boxes and include other information where indicated)*:

- ☐ Pathology Report Only
- ☐ Pathology Report and Pathology Slides
- ☐ Other: _____

Reason for Medical Records Release: ☐ Continuation of Care ☐ Personal Use

Requests are processed daily. Material is sent out within two business days of receiving a valid release *(provided that the material is available)*. Material is sent using Fed-Ex. If you require alternative courier services, please note that here: _____

Please forward the requested information to:
(Please include full address and phone number)

_____

_____

_____

_____

Note:
1. This authorization is only applicable for one year unless indicated otherwise.
2. The patient may revoke the authorization in writing.
3. Treatment is not conditioned upon the patient signing an authorization.
4. The recipient may re-disclose this information unless this box is checked. ☐

Telephone Number: _____

Signature of Patient/Guardian/Referring Physician: _____ Date: _____

Witness Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE

Date Requested Material Sent: _____ Mid-Atlantic Pathology Employee Initials: _____