PROPATH

A Sonic Healthcare Anatomic Pathology Practice

Patient Authorization for Release of Records

Please fax completed form to ProPath at 214.237.1731

Patient Name: ______________________________

Social Security #: ______________________ **Date of Birth:** ______________________

Accession #: ______________________________

Date(s) of Service: All From: ______________ To: ______________

ProPath is hereby authorized and requested to deliver the following items for the above-named patient to the physician/medical facility at the address provided below:

Slide(s) Patient Report(s)

Tissue Block(s) Other: ______________________________

Special Instructions: ______________________________

Send Materials To:

______________________________ ______________________________

Physician / Medical Facility Department / Attention

____

Street Address

____

City State Zip

______________________________ ______________________________

Authorized Signature of Patient or Guardian Date

A photocopy of this authorization is to be considered as valid as the original.

ProPath | 1355 River Bend Drive, Dallas, TX 75247 | **www.ProPath.com** | **P: 214.638.2000** | **P: 800.258.1253**

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