SBMF
South Bend Medical Foundation
3355 Douglas Road, South Bend, IN 46635

PHONE: (574) 234-4176 or (800) 544-0925
FAX: (574) 807-3162

ANATOMIC PATHOLOGY
CONSENT FOR RELEASE OF MEDICAL INFORMATION AND/OR SPECIMENS

Consult requested by_____

Patient Name_____ DOB_____

Address_____

City_____ State_____ Zip_____

Telephone_____ SS # (if available)_____

Insurance Name_____ Policy Number_____

Insurance Address_____

Physician Name_____

Address_____

City_____ State_____ Zip_____

Telephone_____ Fax_____

SPECIMENS TO BE RELEASED

Report Date_____ Accession #_____ ☐ Slide(s) Number sent : _____

☐ Block(s) Number sent : _____

Report Date_____ Accession #_____ ☐ Slide(s) Number sent : _____

☐ Block(s) Number sent : _____

Person Receiving Specimen_____

Facility_____

Address_____

City/State/Zip_____

Sent Via_____ Date Sent_____ Reviewed By_____

*Please return ALL cases within 30 days.

Forward your billing to: ☐ Patient at address above

FEE FOR SERVICE:

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

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

PLEASE CHECK & COMPLETE THE APPROPRIATE FOLLOWING PARAGRAPH

☐ I hereby affirm that I am competent and emancipated and under eighteen (18) years of age and hereby authorize you to release the clinical specimens herein indicated.

☐ I hereby affirm that I am competent and eighteen (18) years of age or older and hereby authorize you to release the clinical specimens herein indicated.

☐ I hereby affirm that the patient, _____ , is incompetent and that I am the parent, guardian, or custodian and hereby authorize you to release the clinical specimens herein indicated.

☐ I hereby affirm that I am the personal representative of the estate of the deceased patient, _____ , and hereby authorize you to release the clinical specimens herein indicated.

☐ I hereby affirm that the deceased patient, _____ , does not have a personal representative and that I am the spouse of the deceased patient and hereby authorize you to release the clinical specimens herein indicated.

☐ I hereby affirm that the deceased patient, _____ , does not have a personal representative or a surviving spouse and that I am a child of the deceased patient and hereby authorize you to release the clinical specimens herein indicated.

☐ I hereby affirm that the deceased patient, _____ , does not have a personal representative or a surviving spouse and that I am the parent, guardian or custodian of an incompetent child of the deceased patient and hereby authorize you to release the clinical specimens herein indicated.

☐ I hereby affirm that I am the parent, guardian or custodian of the fetal remains, and I hereby authorize you to release the fetal remains to _____. I acknowledge the fee for this service has been pre-arranged and is at my expense or that of the hospital.

It is understood that this Consent is subject to revocation by me at any time except to the extent that action has been taken in reliance thereon. This request is valid for six months unless revoked by me in writing. It is also understood that this authorization may be by photocopy of the original.

I agree that I am fully responsible for payment of all charges associated with the release of these specimens and my payment is due to the South Bend Medical Foundation at the time the invoice is received.

I affirm, under the pains of perjury, that the above and foregoing is true.

_____ _____
Signature of Patient or Personal or Legal Representative *Date*

_____ _____
Address *Phone Number*

_____ _____ _____
City *State* *Zip*

☐ I hereby affirm that I have been authorized by the patient/family member to receive the following _____ of _____ .

Signed _____ *Representative of:* _____
Funeral Home