University of Connecticut
Health Center
John Dempsey Hospital
Dept of Pathology &
Laboratory Medicine

(Patient Identification)

Authorization to Obtain and Release Pathology Slides/Reports

1. I hereby authorize UConn Health Center, Department of Pathology and Laboratory Medicine, to release my pathology slides and accompanying pathology report as described here to the person/organization named below. I understand that this authorization is voluntary and that it ***may include information relating to AIDS and HIV infection.***

PATIENT'S NAME:			DATE OF BIRTH:
ADDRESS:			
CITY:	STATE:	TO#:	PHONE NUMBER:

2. Dates of Service_____

   ATTENDING UCHC PHYSICIAN NAME:_____

3. Information: to be released:

   ☐ Pathology report & Pathology slides

4. I am requesting that this information **be released** for the purpose of

   □ Another Medical Appointment Date/Time of appointment: _____

   □ Transfer of care

5. Name of the person(s)/organization(s): **to whom slides/report will be released (Please print legibly)**

PHYSICIAN NAME:			PHONE:
CONTACT PERSON:			PHONE:
DEPARTMENT:			
INSTITUTION:			
MAILING ADDRESS			
CITY	STATE	ZIP	

6. Name and relationship to patient of individual authorized to pick SLIDES/PATHOLOGY REPORT being released from the facility:

   _____

7. I understand this authorization may be revoked **in writing to the Director of Medical Records** at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization shall automatically expire 6 months from the date of signature unless otherwise specified in the space provided here.

   DATE OF EXPIRATION: _____.

8. I understand that I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with copying, not to exceed what Connecticut State law authorizes.

9. UConn Health Center, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

10. I understand that UConn Health Center may not condition treatment on the provision of this authorization except in cases of research-related treatment protocols or studies being conducted by outside third parties through UConn Health Center. In such cases, specific authorization for the research-related treatment protocols/studies must be signed as a condition of participation. In cases where UConn Health Center is requested by a third party to create health information solely for the purpose of sharing that information with the party that requested it, I understand that I must sign this authorization.

HCH1770

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11. **Notice to Recipients:** As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY:
    - *With written authorization from the patient or his or her legal representative;*
    - *As required or authorized by state and / or federal law; or*
    - *If urgently needed for the patient's continued care.*

    If this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

12. **Notice to Individual Requesting the Disclosure:**
    Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and Ch. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Legal Representative — Date

_____ _____
Printed name of Legal Representative * — Relationship to Patient

* A copy of the personal representative's legal authority to act on behalf of the patient is attached.

_____ _____
Signature of Individual Picking up slides/report — Relationship to Patient

This authorization should be submitted to the Department of Pathology and Laboratory Medicine by any of the following methods **at least 4 days** before your appointment to guarantee arrival of slides at the consulting institution:

1.) FAX 860-679-4334
2.) Delivery in person to RM CG052 (Pathology Office) UCONN Health Center
    8:00 AM – 5:00 PM (Monday through Friday)
3.) Mail to:
    DEPARTMENT OF ANATOMIC PATHOLOGY MC 3985
    UNIVERSITY OF CT HEALTH CENTER
    263 FARMINGTON AVENUE
    FARMINGTON CT 06030-3985

For Office Use Only

Sign & Date	
Check identification	
Date records needed by:	
Charges:	
Copy of Authorization was provided to patient	