

**PATIENT REQUEST & CONSENT FOR RELEASE OF ANATOMIC PATHOLOGY MATERIALS**  
 Requests for materials take 3-4 business days for processing. Please address sections 1-5 thoroughly. Missing information below will cause further delay.

Date of Request: \_\_\_\_\_ Name of Requestor: \_\_\_\_\_

Relationship to Patient:  Self  Parent/Legal Guardian  Other (describe) \_\_\_\_\_

1. Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Tufts MC Medical Record Number (if known): \_\_\_\_\_

Address: \_\_\_\_\_ Tel number: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_

2. Purpose of Release:  Second Opinion  Treatment or appointment at another facility\*  
 Other (describe) \_\_\_\_\_

I request and authorize \_\_\_\_\_ Tufts Medical Center Department of Pathology and Lab Medicine \_\_\_\_\_ to release healthcare information including reports, slides, blocks, specimens or medical/surgical hardware of the patient named above to:  SELF or  OTHER (fill in info below).

Contact Name: \_\_\_\_\_ Institution: \_\_\_\_\_

Building/Floor/Box: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

3. Release Request: Please mark the box with your request including applicable case numbers and/or procedures dates

Check Here	MATERIALS	CASE(S) or Date of Procedure
<input type="checkbox"/>	Slides	
<input type="checkbox"/>	Medical/Surgical Hardware	
<input type="checkbox"/>	Blocks	
<input type="checkbox"/>	Reports	
<input type="checkbox"/>	Specimen (limited, requires department and Risk Management approval)	

\*NOTE: Please note upcoming appointment date if applicable:  
 \_\_\_\_\_

4. Shipment: Tufts Medical Center Department of Pathology uses regular US mail for materials shipment. TMC Pathology does not cover the cost of shipping by FedEx or UPS. If these are required, payment is the responsibility of the patient/requestor. Please provide shipping account number or provide pre-paid shipping label if FedEx/UPS shipping chosen.  Regular US Mail

Fed Ex \_\_\_\_\_  UPS \_\_\_\_\_  Patient pick up at TMC Medical Records

Other \_\_\_\_\_

5. Patient/Guardian Signature (required): \_\_\_\_\_

**Materials Release**

Date materials received in Medical Records: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Records Representative: \_\_\_\_\_  
 Patient Signature for Pick up: \_\_\_\_\_  
 Date of Pick Up: \_\_\_\_/\_\_\_\_/\_\_\_\_