*4path, Ltd.*
*8238 S. Madison St.*
*Burr Ridge, IL 60527*
*877-88-4PATH*

# Request for Reprint of Patient Report

FAX to 630-560-0120 Or send to address in header

Please allow 7 working days from receipt of request for processing. All reports are sent by standard 1st class mail.

***INSTRUCTIONS:***
***PLEASE READ CAREFULLY. INCOMPLETE SUBMISSIONS WILL NOT BE PROCESSED. THIS FORM IS FOR <u>REPORT REPRINTS ONLY</u>. DO NOT USE FOR 2nd OPINION REQUESTS***

1. ***Complete ALL information in the box below.***
2. ***A photocopy of both sides (front and back) of the patient's (or authorized agent's) driver's license or other government issued PHOTO identification ("ID") is required to ensure identity of requestor. ID address must match the address to which the report is sent, for authentication purposes.***
3. ***Sign and date under "authorized signature"***
4. ***Reprints are sent ONLY to patient or authorized agent. No second party mailings are provided.***

****** Incomplete submissions will not be processed. *****

***Patient Information and Address for Report Delivery***

_____ _____
***Patient Name*** ***Date of Birth***

_____ _____ _____ _____
***Street Address*** ***City*** ***State*** ***Zip***

***Specimen / Procedure Information***

_____ _____ _____
***Date of Procedure*** ***Physician performing procedure*** ***Procedure / Specimen(s)***

_____
***Location where procedure(s) were performed***

_____
***Report numbers or other relevant procedure information (if available)***

**I authorize the 4path, Ltd. to disclose my personal health information and release a report copy to the above individual at the address provided above.**

*I understand that this release may include information relating to sexually transmitted diseases, AIDS, HIV or any other medical condition. I understand that I have a right to revoke this authorization at any time in writing to 4path, Ltd. at the above address or FAX number. I understand that the revocation will NOT apply to materials which have already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire 90 days from the date it is signed, unless I provide a different expiration date, in writing. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. Signing of this form allows for release of information from 4path, Ltd., but is not required to receive health care from 4path, Ltd. These materials are the property of 4path, Ltd. and are being released to serve the interest of the patient. I understand that I am responsible for the return of any materials within 14 days (such as slides, blocks or other materials which may be provided. Reprinted reports do not need to be returned). If such materials are not returned, I agree to indemnify 4path, Ltd, and it's agents for payment of all claims, demands, settlements, or judgments, costs and expenses on account of or in any way growing out of 4path's inability to defend said claim, demand or lawsuit due to missing materials. This indemnification shall bind me, my heirs, legal representatives and assigns. I also understand that this will constitute an incomplete medical record, which may compromise my future care and/or treatment and I accept responsibility for any adverse outcome that may result due to the release of said materials.*

_____ _____ _____
Authorized Signature Printed Name Date

_____
Authorized Relationship to patient (if same, enter "same"). If by legal declaration, please provide documentation.

4path use only:

Date Received: Path Number(s):

Date Sent out: Materials Released: