THE PATHOLOGY LABORATORY
830 BAYOU PINES DRIVE
LAKE CHARLES, LA. 70601
PH. 436-9557 FAX 439-3085

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Outside Facilities

(1) I hereby authorize **The Pathology Laboratory** to disclose the following information from the health records of:

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

Address: _____ **Telephone:** _____

City, State, Zip: _____ **Cell Phone:** _____

Email Address: _____ **Accession #** _____

Covering the period(s) of health care: From (date): _____ To (date):_____

(2) Information to be disclosed**:**

- ☐ Consultation Reports
- ☐ Pathology slides and Paraffin Blocks
- ☐ Medical Records
- ☐ Itemized Billing
- ☐ Other (please specify)_____

This information is to be disclosed to: _____

Address: _____

For the purpose of:_____

(3) I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: _____

(Patient) (Date)

OR Personal Representative_____ **Relationship**_____ **Date**_____