



Experts in the evolution and care of the skin, hair, and nails

AUTHORIZATION TO RELEASE SPECIMENS, TISSUES, SLIDES, BLOCKS AND REPORTS

I, _____ authorize Illinois Dermatology Institute
(patient name) (date of birth)

Laboratory to release to: _____
(name of institution / physician etc)

(address) (phone number)

- Clinical specimens Tissues Slides Blocks Reports

Date(s): _____ Specimen(s): _____
(type and ID if applicable)

For the purpose of: _____

I understand that I, as the patient, have the right to inspect the materials being disclosed and the right to revoke this consent by written statement at any time.
The released materials may not be re-disclosed to other persons/organizations without my written authorization. Pathology tissue, slides and blocks are a part of the patient's permanent clinical record and are property of the facility that produced them. Loan of these materials is made with express understanding it is not to be loaned to a third party and will be returned to Illinois Dermatology Institute Laboratory within 60-days. I, the undersigned, assume responsibility in case of loss, theft, or damage to these materials while on release under my signature, as well as assure that these materials will be returned to Physician's DermPath Laboratory upon completion of the review / consultation.
This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

(date) (signature of patient / legal guardian) (relationship to patient)

(date) (type of photo ID used for verification)

(date) (signature of individual releasing materials)

Approved by: _____ and/or: Risk Management Notification: _____
(pathologist name / signature)(date) (any case regarding legal / potential legal issues) (name)