SaraPath DIAGNOSTICS
2001 Webber Street, Sarasota, FL 34239-5737 Tel 941.362.8900 Fax 941.362.8971 www.sarapath.com

Consult Facility:
Please fax your consultation Results to SaraPath Diagnostics at (941) 362-8971

MEDICAL REQUEST FOR CONSULT BY PHYSICIAN OR PATIENT

Please Fax this Form to
SaraPath Diagnostics
Medical Records Coordinator
Phone (941) 362-8917 Fax (941) 362-8944
Name of Medical Records Coordinator:

The ☐ Patient, ☐ Physician, ☐ Other: _____ has requested that SaraPath Diagnostics send the enclosed medical specimens and records to your facility for consultation or treatment purposes. SaraPath Diagnostics is not requesting this service and is not responsible for any associated charges. All medical specimens are the custodial property of SaraPath Diagnostics, and are irreplaceable. Do not forward or release materials to other treating facilities or patient, or dispose of specimens without the written consent of SaraPath Diagnostics. Patient materials must be returned to the above address within 30 days, via a traceable carrier.

PATIENT INFORMATION

Patient Name (Last Name, First, M.I.)	Date of Request (MM/DD/YYYY)	Date of Birth (MM/DD/YYYY)
Parent or Guardian if Patient is a Minor (Last Name, First)	Patient Sex ☐ Male ☐ Female	Social Security Number
Patient Address	Patient Home Phone Number ( )	Patient Fax Number ( )
City, State	Zip Code	Date of Service (MM/DD/YYYY)
Patient's Insurance Provider — Insurance Face Sheet Attached ☐	Policy Holder Name (if different)	Date of Birth of Policy Holder
Insurance Provider Address	Group Number	Policy Number
City, State — Zip Code	Date Needed By (MM/DD/YYYY)	Insurance Provider Phone Number ( )

PHYSICIAN INFORMATION

INFORMATION RELEASED TO

MEDICAL SPECIMENS AND RECORDS RELEASED *(TO BE COMPLETED BY PATHOLOGIST)*

SPECIMEN #	SPECIMEN #	SPECIMEN #
☐ ORIGINAL SLIDES #	☐ ORIGINAL SLIDES #	☐ ORIGINAL SLIDES #
☐ BLOCKS #	☐ BLOCKS #	☐ BLOCKS #
☐ RE-CUT SLIDES #	☐ RE-CUT SLIDES #	☐ RE-CUT SLIDES #
☐ COPY OF PATHOLOGY REPORT	☐ COPY OF PATHOLOGY REPORT	☐ COPY OF PATHOLOGY REPORT
Faxed to ( )	Faxed to ( )	Faxed to ( )
☐ DICTATED LETTER *(ATTACHED)*	☐ DICTATED LETTER *(ATTACHED)*	☐ DICTATED LETTER *(ATTACHED)*
Comments:	Comments:	Comments:
Name of Pathologist — Date	Name of Pathologist — Date	Name of Pathologist — Date
☐ OK to Send	☐ OK to Send	☐ OK to Send

EXPRESS CARRIER BILLING:
☐ PATIENT RESPONSIBLE (CURRENTLY $20) ☐ RECIPIENT RESPONSIBLE CARRIER ( ) ACCOUNT #)

DISCLAIMER: By signing this request, the patient, physician, or legal representatives hereby indemnifies and holds harmless SaraPath Diagnostics from any claims, liabilities, injuries, loss, causes of action, cost, damages, fees, and related expenses that may be, now or in the future, associated with the release of the above described items. The patient and/or physician acknowledges the responsibility for all costs from the entity performing the consultation, and by signing this request form grants SaraPath Diagnostics the right to release the patient's medical records and specimens to the above facility. This Medical Request form expires 90 days after the above Date of Request. Patients requesting the release of medical information must sign and date this form, and attach a copy of a valid photo identification (when available) to this form.

Signature of Physician or (His/Her) Representative — Date

Signature of Patient or Parent/Guardian — Date