Medical Release Form

Patient First Name: _____ Patient Last Name: _____ Last 4 Digits SSN: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Phone #: _____ Request Date: _____

Clinician/Physician Name: _____ Group Practice Name: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Specify Date(s) of Service: _____

Ordered By: _____ Purchase Order #: _____

Specify items requested:

☐ Slides Slide Number(s): _____

☐ Report(s)

☐ Tissue (Research) Fresh: ☐ Yes ☐ No If yes, specify specimen site: _____

How would you prefer the materials be delivered? ☐ Fax ☐ Mail ☐ Other: _____

(Above requires approval from Institutional Review Board or IRB)

If by fax, please provide the fax number: _____

If by mail, please provide the address: _____

If you are a patient requesting materials, a copy of your photo ID is required. ☐ Attached

If you are a patient designee or patient representative, notarization is required. ☐ Attached

I grant permission to release my medical records, tissue, and/or slides and agree to release this laboratory, its physicians and employees from any claims, suits, damages, or complications which may occur while in my custody.

Patient Signature: _____ Date: _____

Requesting Designee Signature: _____ Date: _____

Submit completed form to Ariana Sciences

Email: info@arianadx.com

Fax: 615.916.3218