



**United
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Laboratories**

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**Authorization to Release Health Information
(Laboratory Reports, Pathology Slides, Paraffin Blocks, etc.)**

Name of Patient: _____ Birth date: _____

Patient Address: _____

Date(s) of Procedure(s) or Testing: _____

I hereby authorize United Clinical Laboratories, Inc., to disclose to:

Patient Patient Representative _____ or

Requesting Physician: _____

Facility: _____

Address: _____

the following information contained in the medical records of the above named patient.

Test Report(s): _____

This information may be written, electronic (CD or flash drive), or copies of such records.

Requested delivery method: Pick up Mail email Other _____

email address: _____ (non-secure)

Tissue Slide(s) [specify number]: _____ Paraffin Block(s) [specify number]: _____

Pathology Case No(s): _____ Diagnosis (if known): _____

Date: _____
Authorizing Signatory: Patient/Patient Representative

Printed Patient/Patient Representative

Printed Witness

Relationship:

Witness signature

Authorizing Signatory: If the patient is 18 years of age or older and competent to sign, the patient may sign this document. If the patient is under age 18, the patient's parent or legal guardian who is responsible for the care of the minor may sign this document. If the patient is age 18 or older and incompetent to sign this document, the patient's court-appointed legal guardian or attorney-in-fact for health care decisions may sign this document. If the patient is deceased, the patient's court-appointed executor or estate administrator may sign the document. If there is not court-appointed executor or estate administrator of a deceased patient, the patient's spouse, or if the patient does not have a spouse, any responsible member of the patient's family may sign this document.

AP-007 201405 Date Completed: _____ By: _____