RUTGERS
School of Dental Medicine

# CONSENT FOR RELEASE OF INFORMATION

1) I hereby authorize Rutgers University Diagnostic Services to release the following information from the health record(s) of:

Patient Name: _____ Date of Birth: _____

Patient Address: _____ _____

_____ _____

2) This information is to be sent to:

Name: _____ _____

Address: _____ _____

_____ _____

Telephone: _____ _____

3) The information to be released is:

_____ Surgical pathology report – Accession # _____

_____ Slide/s: Laboratory Accession #_____ Total number: _____

_____ Paraffin block/s: Laboratory Accession #_____ Total number: _____

4)

Purpose of Disclosure: _____

_____

5) I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I UNDERSTAND THAT THIS AUTHORIZATION IS SPECIFIC FOR RELEASE ONLY TO THE ABOVE PARTY AND IS VALID FOR ONLY THREE (3) MONTHS.

Signature: _____Date: _____
Relationship to Patient: Self, Legal Guardian, Parent (of minor)

**THESE ARE OUR ORIGINAL FILE SLIDES/PARAFFIN BLOCKS AND MUST BE RETURNED TO US WITHIN 2 WEEKS:**

RUTGERS UNIVERSITY DIAGNOSTIC SERVICES
RUTERS, THE STATE UNIVERSITY OF NEW JERSEY
RUTGERS SCHOOL OF DENTAL MEDICINE,
110 Bergen Street D-880
Newark, NJ 07103

*Office use only:* Slide(s) reviewed: _____Date returned: _____