UCSF Medical Center

Name:
DOB:
MRN:
PCP
Patient ID/Label

Interstitial Lung Disease Program

Pathology Release Form

Dear Patient:

Give this form to the pathology department, if you have had a biopsy, in order to pick up your slides and bring them with you to your appointment.

To: _____
Name of physician or institution

_____
Street address **City** **State** **Zip Code**

I am requesting and authorizing you to release and furnish medical records and information to:

UCSF Interstitial Lung Disease Program
400 Parnassus Ave., Room 591, Box 0359
San Francisco, CA 94143
tele: (415) 353–8764 | fax: (415) 353–8944

The requested records and information pertain to:

_____ _____
Patient/client name **Date of Birth**

This authorization shall become effective immediately and shall remain in effect until _____ .
Date

This authorization is limited to the following records and information:

- **Pathologist's final report**
- **Biopsy slides (bronchoscopic or open lung)**
- **Two unstained, re-cut sections from original blocks for special studies**

The receiver may use the medical records and information authorized only for the purpose of interstitial lung disease diagnosis, treatment or other pulmonary problems.

I understand that the receiving party may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that I have a right to a copy of this authorization upon my request.

_____ _____ _____
Date Signed **Signature of patient/client/parent/guardian/conservator** **Relationship if not patient/client**

☐ **Interpreter Used**

_____
Witness signature (required if patient/client/representative is signing by mark)

Hospital produced form. Send original to releasing provider/facility. Photocopy for patient if requested.