BCM-MEDICAL GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bcmgeneticlabs.org

AUTHORIZATION FOR RELEASE OF SURGICAL TISSUE
AND PATHOLOGY REPORT

SHIP TO: MEDICAL GENETICS LABORATORIES
Baylor College of Medicine
2450 Holcombe, Grand Blvd. - Receiving Dock
Houston, TX 77021-2024

I hereby authorize:
Hospital name: ______________________________
Street Address: ______________________________
City, State, Zip: ______________________________
Phone: (______) ______________________ FAX: (______) ______________________

to release the following pathology specimen and surgical pathology reports of:

NAME (Last, First): ______________________ Date of Birth (mm/dd/yy): ______________
TISSUE TYPE(S): 1) ______________________ 2) ______________________
3) ______________________ 4)______________________

from surgery or procedures performed on the approximate date(s): ______________________

The paraffin embedded tumor block(s) and reports are to be released for the purpose of diagnostic testing to:

Diagnostic Sequencing Laboratory - Medical Genetics Laboratories
Baylor College of Medicine
Grand Blvd. - Receiving Dock
2450 Holcombe Blvd.
Houston, TX 77021-2024
FAX (713) 798-6584
PHONE (713) 798-6555

I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or conditions:

____

Signed by:
Patient: ______________________________ Date: ______________

(or)

Legal Representative: ______________________________ Date: ______________
Relationship to Patient: ______________________________

Upon completion of the diagnostic testing, please return the paraffin embedded specimens to:

____
____
____
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