Mount Sinai Medical Center
Department of Pathology - Box 1194
1468 Madison Avenue @ 100 Street
Annenberg Building, 15th Floor. Room 01
New York, New York 10029-6574
Telephone: **(212) 241-2675** Fax: **(212) 876-4718**

Request for Pathology Slides

☑ FROM: ________________________________ (Patient Name)

☑ **DATE:** ______________________

☑ PATIENT TELEPHONE: ______________________

☑ **NUMBER OF PAGES:** ____________

TO: Pathology Slide Room

FAX BACK TO: (212) 876-4718

This message is intended only for the individual or entity to whom or to which it is addressed and may contain information that is **PRIVILEDGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE** under applicable law. If the reader of the messages not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is **strictly prohibited.** If you have received this communication in error, **please notify the sender immediately by telephone** and return the original communication to me at the address shown above by regular mail United States Postal Service. **Thank you.**

PAYMENT: The processing fee for all requests is **$ 25.00**. Additional charges will apply if unstained slides are requested by your physician. **CREDIT CARDS and CHECKS are the only forms of payment we accept**. Cash is not accepted and we do not bill your insurance.
PROCESSING TIMES: 5 to 7 business days after request is received, excluding weekends & holidays.

Authorization form (HIPAA) must be entirely completed before your request can be processed. **Check marks indicate required information. If you did not receive all 3 pages or have questions, call (212) 241-0440.**

1. Please provide the following information for the doctor, hospital or facility that the slides will be sent or taken to:

Doctor's Name: ________________________________

Street Address: ________________________________

City: ____________________ **State:** __________ **Zip Code:** __________

Telephone: ________________________

2. Indicate the manner by which you want the requested slides/report handled:

☐ **Patient Pick Up** (WE WILL CONTACT YOU WHEN YOUR REQUEST IS READY)

Slides Received By: ____________________ *Date:* ____________

☐ **UPS Express Mail** (Additional charges will apply. Price based on destination)

☐ **Messenger pick up** (Please provide the service & authorization letter for pick up)

3. MOUNT SINAI USE ONLY:

Pathologist: ____________________

Case Number: ____________________

Slides: ____________________

Unstained Slides: ____________________

Approved By: ____________________ Pathologist

Pathologist: ____________________

Case Number: ____________________

Slides: ____________________

Unstained Slides: ____________________

Approved By: ____________________ Pathologist

AUTHORIZATION FOR RELEASE OF RECORDS INCLUDING HEALTH INFORMATION PURSUANT TO HIPAA

(This form has been approved by the New York State Department of Health) **OCA Official Form No. 960**

☑ **Patient Name:**	☑ **Date of Birth:**
☑ **Patient's Address:**	☑ **Tel. Number**

I, or my authorized representative, request that records, which may include health information regarding my care and treatment, be released as set forth below. In accordance with the New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I check the appropriate box in item 9. In the event the health information describe below includes any of these types of information, and I check the box in item 9, I specifically authorize release of such information to the person(s) indicated below. (*Human Immunodeficiency Virus that causes AIDS. The New York Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person contacts.)

2. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

3. I understand that signing this autorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits, will not be conditioned upon my authorization of this disclosure.

4. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted below in item number 5. And this re-disclosure may no longer be protected by federal or state law.

5. If I am authorization the release of HIV-related, ALCOHOL or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212)305-7450. These agencies are responsible for protecting my rights.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE UNLESS SPECIFIED IN BOX 9(b) BELOW.**

The name of the DOCTOR, Address and Tel. Number is required before releasing the slide/s. (see No. 8)

7. Name/address of health provider/entity to release this information: **Mt. Sinai Medical Center** **Pathology Department** **1468 Madison Avenue @ 100 Street** **Annenberg Bldg,** **15 fl Room 15-01** **New York, N.Y. 10029-6574**	☑ **8. Under State Law we need the information where you'r taking the slides:** **Dr.** **Tel. No.**
9. (a) Specific information to be released: Authorization to Discuss Health Information. (**b**)By initially here ________________________(initials) I authorize ____ to discuss my health inform With my attorney, or a governmental ageny, listed here.	☑ **9. (c) Date of Procedure that was done in Mt. Sinai** **If you have the specimen number please write it down**:
☑ **10** ____ **Signature of patient or representative authorized by law**	☑ **11.** **Date:** ____

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Credit Card Payment Authorization Form

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

☑ Card #:____

☑ Exp. Date: ____

☑ Please print your name: _______________________________________

☑ Print patient name: ____
(If payer is not patient)

☑ Signature: ____

☑ Date: ____

This credit authorization form will be shredded once this payment has been successfully processed.