AUTHORIZATION FOR RELEASE OF MATERIALS AND INFORMATION

For Continuation of Patient Care

Name of Patient: _____ **Date of Birth:** _____

Address: _____

Telephone: _____ **Date(s) of Delivery(ies) or Loss(es):** _____

I hereby authorize _____ **(Hospital or Pathology Service)**

To produce and send H&E slides from ALL blocks (recuts preferred, originals accepted) made from my placenta(s) or products of conception, and the pathology report(s) to:

Harvey J. Kliman, MD, PhD
Yale University School of Medicine
Department of Obstetrics and Gynecology
310 Cedar Street, FMB 225
New Haven, CT 06510
203-785-7642 (Lab Phone)
203-737-4397 (Office Fax)

I voluntarily consent to disclose the above information to the person named above. This may include drug and /or alcohol abuse records, mental health records and/or HIV (AIDS) information which may be present in my medical record.

I understand that the refusal to grant consent to release information will not jeopardize my right to obtain present or future treatment.

I understand that this consent may be revoked at any time except to the extent that information has already been released pursuant to this authorization.

I have read and agree to the Yale University School of Medicine Notice of Privacy Practices.

Signature of Patient _____ **Date** _____

Please contact us if you have any questions or concerns about this process:

Kliman Lab Office: 203-785-7642; kristin.milano@yale.edu

Harvey Kliman, MD, PhD: 203-785-3854; harvey.kliman@yale.edu

See the following page for shipping charges instructions.

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*****For Continuation of Patient Care*****

If the originating pathology department does not pay for the shipping of pathology materials to consultation services such as ours, we will require you to pay for the shipping. You will be charged a reduced corporate rate through our Yale FedEx account. Such charges typically range between $10-20.

Name of Patient: _____ **Date of Birth:** _____

Billing address (including zip code): _____

_____

Telephone: _____ **Email:** _____

I hereby authorize Kliman Laboratories to charge the following credit card for any shipping charges incurred for the request for my pathology materials.

Patient Signature: _____ **Date:** _____

Please check one: ❑ **Visa** ❑ **Mastercard** ❑ **Discover**

Credit Card Number: _____

Expiration Date: _____ **CVV:** _____

Cardholder name if other than patient: _____

Cardholder signature if other than patient: _____

Cardholder billing zip code if other than patient: _____

Please note: A receipt will be available at the patient's request. This credit authorization form will be shredded once this payment has been successfully processed.

Please contact Kliman Labs at 203-785-7642 or kristin.milano@yale.edu for any shipping questions or concerns.

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