

THE JOINT PATHOLOGY CENTER REQUEST FOR RELEASE OF PATIENT MATERIAL			
INSTRUCTIONS: 1. Healthcare facility that originally submitted patient material to JPC: Complete Part A of this form and fax, along with your health care facility's Fax Cover Sheet to: J PC. ATTN: Special Handling Office. Fax number 301-295-5661. 2. Patients, Outside Facility or Legal representatives requesting release of patient material: Complete Part A of this form and complete a DD Form 2870, Authorization for Disclosure of Medical or Dental Information or another HIPAA approved patient consent form. Fax forms to: JPC. ATTN: Special Handling Office. Fax number 301-295-0104 and 301-295-5661. Please Note: Attorneys may submit a Court Subpoena in lieu of the DD Form 2870 or HIPAA approved patient consent form.			
PART A - TO BE COMPLETED BY REQUESTOR			PART B - TO BE COMPLETED BY JPC
CASE IDENTIFICATION <i>(Required)</i>			
1. PATIENT'S LAST NAME:	2. FIRST:	3. MI:	8. DATE RECEIVED: (YYYYMMDD)
4. SURGICAL/AUTOPSY NUMBER:			9. SPECIAL HANDLING OFFICE:
5. JPC/AFIP ACCESSION NUMBER:			10. PATHOLOGY SPECIALTY:
6. CASE MATERIAL REQUESTED <i>(Required)</i>			11. JPC PATHOLOGIST COMMENT SECTION
☐ H&E ☐ IMMUNO SLIDES ☐ SPECIAL STAIN SLIDES ☐ BLOCKS ☐ OTHER _____ MATERIAL REQUESTED FOR: <i>(Select One)</i> ☐ LOAN or ☐ PERMANENT RELEASE			RECOMMEND THE FOLLOWING MATERIAL: ☐ H&E ☐ FROZEN ☐ IMMUNOS ☐ SPECIAL STAINS ☐ ALL SLIDES ☐ BLOCKS ☐ DIGITIZE SLIDES ☐ OTHER _____ ☐ SLIDE SETS HAVE BEEN MADE AND ARE ATTACHED
7. REQUESTOR IDENTIFICATION <i>(Required)</i>			12. REMARKS: 13. SIGNATURE: 14. DATE: (YYYYMMDD) Return to Special Handling Office. PART C - Completed by Spec. Handling/Designee RECEIVED FROM SUBSPECIALTY 15. DATE: (YYYYMMDD) SENT TO REQUESTOR 16. DATE: (YYYYMMDD) 17. INITIALS OF TECH:
REQUESTOR'S NAME:			
NAME OF FACILITY:			
ADDRESS:			
CITY:			
STATE:	ZIP:	COUNTRY:	
TELEPHONE:	FAX:		
EMAIL:			
EXPRESS MAIL ACCOUNT NUMBER:			