SEPA Labs
SOUTHEASTERN PATHOLOGY ASSOCIATES

CAP ACCREDITED

I hereby authorize Southeastern Pathology Associates of Brunswick, Georgia to release the following information from the medical record of:

Patient's Name: _____

Patient's Date of Birth: _____

Appointment: _____

	Pathology Slides Accession #: _____		Tissue Blocks
	Pathology Reports Accession #: _____		Drug/Alcohol Results
	HIV/AIDS testing information		Other:

This information is to be sent to (Include Clinic name, Address, and a contact number):

_____

_____

_____

_____

State and federal confidentiality provisions prohibit the release of the information specified above to any individual or agency other than the one indicated above.

This release of information authorization can be revoked with written notification except to extent that the action has been taken. This consent is valid for 90 days after the date of signature.

Please include a copy of the patients photo ID.

_____ _____ _____

Signature Printed Name Date