

DOCUMENTATION FOR CONTINUUM OF CARE REQUEST

**Department of Clinical Laboratories
The Ohio State University Wexner Medical Center**

HIPAA regulations allow for release of medical information without patient consent in special situations when failure to disclose would negatively impact patient care and treatment. Complete this form to document the need for protected medical information and fax to (614) 293-4255. Allow 5-7 days to complete the request.

Date of request: _____

Send slides to : _____
(hospital / facility name)

(delivery address)

(city, state, & zip)

_____ (phone number) _____ (fax number)

Requesting Physician: _____
(print name of Physician)

(physician's signature)

Patient Name: _____

Birth Date: _____ Surg Path# (if known): _____

Approximate date of service at OSU Medical Center: _____

I. Items requested: *(check all that apply)*

- Pathology Report
- Stained Slide(s)
- Unstained Slide(s) (only for special circumstances; call our office if needed)
- Other _____

[Please Note: Paraffin embedded tissue blocks will not be released]

II. Reason for request:

- Followup appointment
- Second opinion
- Comparison of current / previous results
- Research / Clinical study
- Other _____

If you need assistance with this form, please contact the Program Assistant at the Renal Pathology division: Phone: 614-293-9258, Fax: 614-293-4255