



Marlboro-Chesterfield Pathology, P.C.
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CONSENT FOR RELEASE OF INFORMATION

Name of Patient: _____

MARLBORO-CHESTERFIELD PATHOLOGY is hereby authorized to release to:

Agency or Individual Receiving information

the following information or documents:

to be used in connection with the following purpose or need: _____

I hereby release MARLBORO-CHESTERFIELD PATHOLOGY and its agents and employees from any and all liabilities and responsibilities, and damages and claims which might arise from the release of information authorized above. I acknowledge that this consent is valid for ninety (90) days or until _____ 20____. I further understand that I can withdraw this consent for release at any time prior to its expiration.

Date

Signature of Patient

Date

Witness

Special circumstances which necessitate other than patient's signature:

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT SUFFICIENT for this purpose. An oral disclosure may be accompanied or followed by such a notice.