Date: [Date]

To: [Name of Pathology Laboratory/Hospital]
Department: Pathology Department / Medical Records
Address: [Address of Facility]

Subject: Authorization for Release of Pathology Reports and Records

Patient Name: [Full Legal Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Medical Record Number: [Number if known]

To Whom It May Concern,

I hereby authorize [Name of Facility] to release my pathology reports and related medical records to the individual or organization listed below:

Recipient Name/Organization: [Name of Doctor or Institution]
Phone Number: [Recipient Phone]
Fax Number: [Recipient Fax]
Email/Address: [Recipient Contact Info]

Information to be Released:

- All pathology reports regarding [Specific Procedure or Date]
- Biopsy results
- Laboratory findings
- Surgical pathology reports

Purpose of Disclosure: [e.g., Continued medical treatment, Second opinion, or Personal records]

This authorization is valid until [Date] or until I revoke it in writing. I understand that I have the right to revoke this authorization at any time.

Thank you for your prompt attention to this request.

Sincerely,

_____
[Patient Signature]

Phone Number: [Your Phone Number]