*Patient Report Request Form*

To request a patient report, please complete the information below and email the form to:

pathconsults@uthscsa.edu

 **Patient & Requesting Physician Information (required)**

|  |  |  |
| --- | --- | --- |
| Request Date | Patient Name (Last, First, Middle) | Patient Date of Birth |
| Date of Specimen Collection  | Specimen Accession # (if available) |
| Requesting Physician/Facility (Full Name) | Address |
| Requested by: (Full Name) | Phone# | Email  |
| Special Instructions |

Note:

\*Requests received before 3:00 p.m. will be handled by the end of the current business day.

\*If the requestor is not the original requesting physician and/or facility, a **Patient Authorization for Release of Health Records to External Parties** will need to be submitted with this request.