

## *Patient Report Request Form*

To request a patient report, please complete this form and email to:  
[pathconsults@uthscsa.edu](mailto:pathconsults@uthscsa.edu)

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**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:		

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**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.