DAHL-CHASE
DIAGNOSTIC SERVICES

SPECIMEN RELEASE FORM- MERCY HOSPITAL

RE: Release of ____

I understand that surgical specimens are the property of Dahl-Chase Diagnostic Services (DCDS) and that DCDS will release the specimen listed above to me at their discretion. By signing this paper I understand that I undertake all responsibility in the handling of this tissue/specimen. DCDS cannot be held liable for any reason once the tissue specimen is under my control or the control of my designee.

I understand that the specimen has been exposed to 10% formalin which has the following caution: **FORMALDEHYDE:** Toxic by inhalation and if swallowed. Irritating the eyes, respiratory system, and skin. May cause sensitization by inhalation or skin contact. Risk of serious damage to the eyes. May cause cancer. Repeated or prolonged exposure increases the risk.

I further understand that the specimen is a considered a biohazard. Although the specimen has been disinfected in 10% formalin for a minimum of 72 hours there may still be a risk of infection.

Specimens may be retrieved from Mercy Laboratory (175 Fore River Pkwy Portland ME) 16 days after surgery from a Dahl-Chase representative. Please contact DCDS at 879-3170 to ensure specimen is prepared for retrieval. DCDS will **not** initiate contact with you to retrieve the specimen. DCDS will hold the specimen up to 45 days after the date of surgery. Once the 45 day period elapses, the request for release will be voided and the specimen will be discarded per the appropriate protocol.

Designate how the specimen will be retrieved:
- ☐ Patient will pick up
- ☐ Designee will retrieve specimen (Full name: ____________________________)
- ☐ Funeral Home will pick up (Funeral Home: ______________________________)

HIPAA DISCLOSURE: I have been fully advised of my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I intend for this authorization to satisfy the requirements of HIPAA. In regard that I certify that I consent to the release of my specimen (protected information) to any designee stated above.

I, ____(print), the patient requesting the specimen, have read and understand the above.

PATIENT SIGNATURE: ______________________________________DATE: ___________

WITNESS: ____ DATE: ___________

Return this form to Dahl-Chase Diagnostic Services within 13 days following the surgical procedure or the specimen may be disposed of per normal protocol.
Please return to Dahl-Chase Diagnostic Services/Pathology by mail or fax:
Address: 417 State Street, Webber West, Ste. 540 Bangor, Maine 04401
Fax: 990-4848

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Signature upon receipt of specimen: ___________________________ DATE:___________