



COLUMBIA UNIVERSITY
MEDICAL CENTER

In affiliation with
NewYork-Presbyterian Hospital

REQUEST FOR SLIDES

Name of Institution: _____

Attention: _____

Fax No: _____

From: _____

Mail to: **Herbert Irving Pavilion**
 161 Fort Washington Ave, 8th Floor – Suite 837
 New York, NY 10032
 Telephone No: 212-305-3410
 Fax No: 212-305-3412

Accession/Specimen No: _____

Patient Last Name: _____ **First Name:** _____

DOB: _____

Social Security No: _____

MRN (NYP – COLUMBIA): _____

I authorized the release of my slides and report(s) to the above mentioned physician or medical practice.

Print Name

Signature

Date