AUTHORIZATION FOR REVIEW OF PREGNANCY SPECIMENS

Name of Patient: _____ **Date of Birth:** _____

Address: _____

Telephone: _____ **Email:** _____

Please check all that apply

❑ **I DO have insurance**

- If my insurance carrier denies payment, I agree to be personally and fully responsible for payment.
- I have enclosed copies of both sides of my insurance card.
- I have registered with Yale Medicine by calling 1-888-639-9253 and my medical record (MR) number is: _____

❑ **I DO NOT have insurance OR I prefer to pay for this review as follows:**

- ❑ I have enclosed a cashier's check or money order in the amount of $_____ ($360 per pregnancy slide review) made payable to Yale University.
- ❑ I wish to have the consult fee(s) charged to my credit card ($360 per pregnancy):

Credit card ($360/pregnancy): VISA ❐ **or** MasterCard ❐ **(we do not accept American Express)**

Card holder Tel#: _____ **Name on card:** _____

Card number: _____ **CVV**_____**Exp date:** mm | yy

House Number & Street: _____ **State/Province:** _____

City: _____ **Zip or postal code:** _____

I hereby authorize Harvey Kliman, MD, PhD to review my pregnancy pathology specimens.

Signature of patient _____ **Date** _____

If paying by check, mail your check and this form to:

Harvey J. Kliman, MD, PhD
Yale University School of Medicine
Department of Obstetrics and Gynecology
310 Cedar Street, FMB 225
New Haven, CT 06510

or if using a credit card, scan this form and email or fax to: 203-785-4477