MR #

DOB

NAME

DATE

* 9 6 7 0 *

BASSETT HEALTHCARE NETWORK

☐ **BASSETT MEDICAL CENTER**
Cooperstown, NY 13326-1394

☐ **LITTLE FALLS HOSPITAL**
Little Falls, New York 13365

☐ **COBLESKILL REGIONAL HOSPITAL**
Cobleskill, New York 12043

☐ **FOXCARE CLINIC**
Oneonta, New York 13820

☐ **HAMILTON SPECIALTY SERVICES**
Hamilton, New York 13346

☐ **HARTWICK SEMINARY SPECIALTY SERVICES**
Milford, New York 13807

☐ **BASSETT HEALTHCARE HERKIMER**
Herkimer, New York 13350

☐ **O'CONNOR HOSPITAL**
Delhi, NY 13753

☐ **ONEONTA SURGICAL ASSOCIATES**
Oneonta, New York 13820

☐ **ONEONTA SPECIALTY SERVICES**
Oneonta, New York 13820

☐ **TRI TOWN REGIONAL HOSPITAL**
Sidney, New York 13838

_____ Health Center

SPECIMEN RELEASE FORM

H-9670 10/15 (d\forms\hosp\.ofm)

Re: Release of specimen (description): _____

Bassett Pathology Department will hold the specimen for two weeks after the report is finalized. After that time, the specimen will be discarded per the laboratory protocol.

This form acknowledges the receipt of specimen _____, which I have indicated to the Pathology Department that I would like to have for

☐ religious ☐ cultural or ☐ burial purposes.

I understand that surgical specimens are the property of Bassett Healthcare Network and that Pathology has released this tissue specimen to me at their discretion. By signing this form I understand that I undertake all responsibility for handling the tissue. Bassett Healthcare Network cannot be held liable for any reason once the tissue specimen is under my control.

I understand that the specimen may have been in 10% formalin, which has the following caution:
FORMALDEHYDE: Toxic by inhalation and if swallowed. Irritating to 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 biohazard specimen (may create the risk for exposure to infectious diseases, i.e., HIV, hepatitis and tuberculosis).

I, _____, the patient requesting the tissue specimen, have read and understand the above

Witness: _____ Date: _____

Clinician's signature: _____

Request approved: _____ Administrator on Call

_____ Risk Management

_____ Chief of Pathology

Request denied – clinician notified: _____

ACKNOWLEDGEMENT