

ROBERT GUTHRIE BIOCHEMICAL & MOLECULAR GENETICS LABORATORY

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THE BUFFALO GENERAL HOSPITAL

KALEIDA HEALTH

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CLIA License #33D0685375 New York State Laboratory Permit #PF12005

**SPECIMEN RELEASE
FORM
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Please fill out ALL information requested below. Incomplete or incorrect information may delay transfer of specimens. Please note that you must pre-arrange for payment of shipping through your preferred carrier and provide our laboratory with your account number and internal billing number for frozen specimens. Please see details below. Fax this form back to us at (716) 859-7749.

Date: _____

Person requesting specimen transfer: _____

Address: _____ City, State, Zip _____

Phone Number: _____

Patient Name: _____ Patient Date of Birth: _____

Specimen(s) to be transferred: _____

Facility Receiving Specimen: _____

Facility Address: _____ City, State, Zip _____

Facility Phone Number: _____

Purpose of Specimen Send-Out: _____

I hereby authorize Kaleida Health Laboratories to release the above-named specimens. I relieve Kaleida Health Laboratories from any liability regarding any damage or loss of the specimens during shipping and subsequent testing. I understand that there is a pre-payment required for the shipping of frozen specimens to the above named facility is required.

Signature of Parent, Legal Guardian, or Patient

Date

Signature of Witness (Required)

Date