AUTHORIZATION FOR REVIEW OF PREGNANCY SPECIMENS

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

Address: _____

Telephone: _____ **Email:** _____

Please check all that apply

❑ **Please forward a formal report of Dr. Kliman's review to my physician: (name, address, email):** _____

_____

❑ **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 called Yale Medicine Registration at 1-888-639-9253 and my MR# 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 $_____ ($260 per loss) made payable to Yale University.
- ❑ I wish to have the consult fee(s) charged to my credit card ($260 per pregnancy):

Credit card ($260/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** _____

Please mail checks 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 fax if using a credit card to: 203-785-4477