

AUTHORIZATION FOR REVIEW OF PREGNANCY LOSS 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 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 loss):

Credit card (\$260/loss):  or  Card holder Tel#: _____

Name on card: _____ Card number: _____ Exp: mm | yy

House Number & Street: _____ State/Province: _____

City: _____ Zip or postal code: _____

I hereby authorize Harvey Kliman, MD, PhD to review my pregnancy loss 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
300 George Street, Suite 770
New Haven, Connecticut 06511

or fax if using a credit card to: 203-785-4477