**Authorization Letter**

Date: / /2020

To:

The Histopathology Department,

Name of Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subject: Request for Paraffin Embedded Block of the patient Mr./Mrs.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Case No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Sir / Madam,

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ had undergone Breast Cancer Surgery on date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, operated by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

My doctor had suggested ordering the Oncotype DX Breast Recurrence Score® test. For the test, Paraffin Embedded Block containing the invasive tumor tissue is required. So I kindly request you to release the specimen.

After the report release of Oncotype DX Breast Recurrence Score® test, I will return the block to your department.

Thank You.

**Date of Operation:**

Yours truly,

 (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)