Authorization for Release of Protected Health Information

Patient Name____________________Date of Birth___________SS#_______________________
Address of patient_______________________City_________________State____Zip___________
Telephone # of patient__________________________________
Date of death:____

I hereby authorize (Hospital or Facility Name) Autopsy and Pathology Services, P.A. and Jessie Adame, M.D. and Albert I.Chen, M.D.

Autopsy Date:____

to release information from the medical records of the above indicated patient to:

____
______________________________**(address-Please Print)**
____
______________________________**(fax number-if applicable)**

for the following purpose: ____

Abstract/Pertinent Information	Lab	MD Progress Notes	Emergency Room
Imaging/Radiology	MD Orders	H & P	Cardiac Studies
Entire Record	Consultation	Face Sheet	Discharge Summary
Operative/Procedure Report	Nursing Notes	Other: **ALL AUTOPSY INFORMATION/REPORTS**	

This authorization expires 180 days from the date signed below and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of the facilities indicated above to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from release of this information and I, the undersigned, waive, on behalf of myself, my heirs, assigns and any person who may have an interest in the matter, all provisions of law relating to the disclosure of this Protected Health Information.

A photostat of this authorization is acceptable with the same authority as the original.

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.

__________ ____
Date Signature of Patient/Parent/Conservator/Guardian

____
Authority/Relationship to Patient

NOTE: PLEASE FILL OUT ALL LINES. PLEASE DO NOT LEAVE ANY BLANKS.