Authorization for Release of Protected Health Information

Patient Name_____Date of Birth_____SS#_____
Medical Record # (if known)_____
Address of patient_____City_____State____Zip_____
Telephone # of patient_____

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

Treatment Dates:_____

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

_____(Attorney at Law)
_____
_____ **(Fax-if applicable)**_____

for the following purpose: possible medicolegal issues

Abstract/Pertinent Information	Lab	MD Progress Notes	Emergency Room
Imaging/Radiology	MD Orders	H & P	Cardiac Studies
Consultation	Face Sheet	Discharge Summary	Nursing Notes
Operative/Procedure Report	Other: ***All reports, billing records, and other documents associated with the autopsy; specimens, specimen recuts, autopsy photographs***		

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 I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it.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.