AUTHORIZATION FOR RELEASE OF INFORMATION FOR AUTOPSY RELATED RECORDS

INSTRUCTIONS: Fill in an answer to each item below. The patient or patient's legal representative must sign this completed authorization before any information will be released.

Patient Name:_____
First Middle Last

Address:_____ Date of Birth:_____

Address:_____ Social Security Number:_____

Phone:_____ Fax:_____

I hereby authorize_____to release certain information, including psychiatric information.
(Name of doctor or facility **RELEASING** information – **please list all applicable facilities**)

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Information/Records To Be Released To:
University of Kentucky Medical Center
Department of Pathology & Laboratory Medicine
800 Rose Street, Suite MS117
Lexington, Kentucky 40536
Phone: 859-323-5425 **Fax: 859-323-2094**

Information to be released covers the period(s) of hospitalization from _____through _____

and/or outpatient treatment(s) on_____.

1. **INFORMATION TO BE RELEASED**: (Check all appropriate boxes)

☐ Discharge Summary ☐ Pathology Report(s) ☐ X-Ray Report(s) ☐ Outpatient Notes

☐ Operative Report(s) ☐ Laboratory Report(s) ☐ X-Ray Film(s) ☐ Emergency Department Notes

☐ Other: (specify)_____

2. I understand that the information that is released may include information pertaining to the diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS), and/or information pertaining to the diagnosis or treatment of drug and/or alcohol abuse prior to August 1987 that may be contained in the items checked above in question #1.
☐ YES ☐ NO ☐ N/A

I understand the released information will be used for the purpose of:_____**Autopsy**_____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred. I also understand this authorization will expire automatically sixty (60) days from the date below.

The facility, its employees and officers, and attending physician(s) are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

_____ _____
Date Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:

_____
Signature of Legal Representative and Relationship to Patient

☐ Minor ☐ Incompetent ☑ **Deceased**

_____
Signature of Witness

_____
Interpreter Name or ID # In person or via Cyracom (circle one)