THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Department of Pathology
Division of Autopsy Services

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The Ohio State University Medical Center
Department of Pathology
Division of Autopsy Services
005 & 081 Davis H.L.R.I.
473 West 12th Avenue
Columbus, Ohio 43210-1252
PH: 614-247-7499 or 614-247-7485
FAX: 614-685-4167

Patient Name: _____ **Date of Birth:** _____

Last 4 Digits of Patient's Social Security: _____ **Date of Death:** _____

Next of Kin Name: _____ **Relationship:** _____

I Authorize (please fill in facility or physician below):

Facility or Physician:	Phone: Fax:
Facility or Physician:	Phone: Fax:
Facility or Physician:	Phone: Fax:
Facility or Physician:	Phone: Fax:
Facility or Physician:	Phone: Fax:

To Release Medical Information to: **The Ohio State University Medical Center**
Department of Pathology, Division of Autopsy Services
005 & 081 Davis H.L.R.I., 473 West 12th Avenue
Columbus, Ohio 43210-1252

Purpose of Disclosure: To Aid in Conducting an Autopsy

Dates of Service: _____

Specific Reports to be Disclosed:

❑ Emergency Department Reports	❑ Operative Reports	❑ Assessment
❑ Discharge Summary	❑ Physical/Occupational Therapy Notes	❑ Treatment Plan
❑ Laboratory Reports	❑ Pathology Reports	❑ Progress Notes
❑ History & Physical	❑ Radiology Reports	❑ Admission Note
❑ Social Work Notes	❑ Other: _____	

Per Ohio Revised Code 3701.741, you may be charged a fee for copies of medical records.
I hereby authorize the treatment facility indicated above and its employees to release medical information contained in the deceased's patient record or designated record set. I understand and acknowledge that this authorization extends to all of the information above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact that an HIV test was performed. Information in the form of photography shall also be included as part of this request, if applicable. A separate authorization is required for the release of psychotherapy notes. I expressly consent to the release of information designated above. This authorization is valid for 365 days, unless revoked by my written notice, provided said notice is received prior to release of the above information. *The revocation of this authorization is effective except as indicated in The Ohio State University Health System's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA.* I understand that The Ohio State University Medical Center cannot condition payment for health care on this Authorization unless the treatment is research-related or the care was provided solely to provide information for the third party.

X_____ _____
Signature of Next of Kin/Person Authorized to Consent **Date Signed:**

X_____
Relationship to patient

X_____ _____
Witness (Optional) **Date Signed:**

For records covered by 42 CFR Part 2: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

ROI