Public Health/King County Medical Examiner is not obligated to honor this request unless all portions are completed.

The undersigned authorizes the King County Medical Examiner's Office, an office of Public Health – Seattle & King County, to release the records of:

Decedent's Name

Date of Death | Medical Examiner Case Number

Date of Birth | Place of Death

Records will be released to:

Person & Institutional Affiliation

Street Address | City/Zip

This release covers the following date(s): This request will cover the complete medical examiner case file from report of the death to close of the case, unless specific dates are requested here: _____

For the purpose of: ☐ medical ☐ legal ☐ personal ☐ other: _____

Unless revoked or as otherwise provided herein, this authorization expires _____ **(insert either applicable date or event)**. Is the person or organization to which the client's records will be released an employer or financial institution i.e. bank? Yes ☐ No ☐ If yes, this authorization will expire 90 days from date signed (or such earlier date as indicated on the authorization).

Records Requested: (Photo identification may be required to verify identity)

- ☐ Autopsy Report
- ☐ Medical Examiner Photographs
- ☐ Verbal Exchange: _____
- ☐ Scene Investigator's Report
- ☐ Other: _____

I understand that the records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. When checked, this authorization **excludes** release of the following types of information:

- ☐ Drug or alcohol abuse diagnosis or treatment
- ☐ Confirmed STD test results and/or treatment
- ☐ HIV (AIDS) testing/treatment
- ☐ Psychiatric care/mental illness

Next of Kin/Personal Representative Signature | Relationship | Date

Interpreter | Date

Your rights under federal and state law:

- You may revoke this authorization at any time. It must be in writing. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable.
- Public Health may not refuse treatment to you or the person under your guardianship if you do not sign this form.
- When Public Health asks you to fill out this authorization, you are entitled to a copy.
- When Public Health discloses your health information, your protected health information can be subject to re-disclosure by the recipient and is no longer protected by Public Health.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND CONFIDENTIAL AUTOPSY INFORMATION

King County Medical Examiner's Office
Harborview Medical Center
325 Ninth Avenue, Box 359792
Seattle, WA 98104-2499
206-731-3232 Fax 206-731-8555
TTY Relay: 711
www.kingcounty.gov/health

Public Health
Seattle & King County