PRIVATE AUTOPSY SERVICES

6517 North Armenia Avenue – Tampa, Florida 33604

Phone: (813) 288-6779 Fax: (813) 932-0077 www.autopsyflorida.com

Email: Autopsies@AutopsyFlorida.com

Jose V. SuarezHoyos, M.D.

Release of medical records

I request _____

(Name of hospital/Physician to disclose information)

_____

Address

_____ _____

Phone # Fax #

Release of medical records for _____ Born on _____to be

(Name of patient) (Date of birth)

Released to: Private Autopsy Services, llc FAX: 813-932-0077

Attention: **Loree Meadows**, General Manager

The following information is being requested:

( ) Entire medical record held by the provider.

( ) **DISCHARGE SUMMARIES OPERATIVE REPORTS H&P PROCEDURES**

( ) **RADIOLOGY** AND **PATHOLOGY** REPORTS **All COVID Test results**

( ) All COVID Test results

( ) Other specific record(s): Please describe _____

For the dates: ( ) All dates of treatment OR ( ) From _____ through _____

For the following purpose: **AUTOPSY**

SPECIFIC UNDERSTANDING:

I *understand* that I may revoke this authorization at any time by notifying the provider in writing, except to the extent that the provider has taken action in reliance on this authorization.

I *understand* that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

I *understand* that the information disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other privacy laws.

I *understand* that by signing this authorization, I authorize the provider to disclose the information identified above and related information necessary to accomplish the purpose described above.

_____ _____

(Signature of patient or personal representative) (Date)

_____ _____

(Printed name of personal representative) (Description of the representative's authority)