



Vermont Department of Health
OFFICE OF THE CHIEF MEDICAL EXAMINER
Authorization For Use and Disclosure of Health Information

Decedent's Name: _____

I authorize the Vermont Department of Health, Office of the Chief Medical Examiner, to release information to:

(person/agency, address, phone)

_____	_____
_____	_____
_____	_____
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I authorize the Vermont Department of Health, Office of the Chief Medical Examiner to share the following types of information: (identify specifically)

- Final Report of Autopsy
 Other:

Purpose of the requested use or disclosure: (identify specifically)

Statement of Understanding. I understand the following:

- The reason(s) I am being asked to release information.
- I do not have to consent to the release of this information.
- Signing this authorization is voluntary.
- If I am authorizing the Agency of Human Services (AHS) to share information about **HIV-related or alcohol or drug treatment information**, the recipient may not share this information with others unless permitted to do so under state or federal law.
- Other types of health information used and disclosed in this authorization may be subject to re-disclosure and no longer protected under state or federal law.
- I may revoke this authorization at any time except to the extent that it has been acted upon. To revoke this authorization, I must write to Office of the Chief Medical Examiner at 111 Colchester Avenue, Baird 1, Burlington, VT 05401.
- If I do not revoke this authorization it will be in effect until _____. If I fail to specify an expiration date, this authorization will expire in six months.
- I will be provided with a copy of this form.

All items on this form have been completed and my questions about this form have been answered.

Signature of Individual OR Authorized Personal Representative	Relationship to Decedent	Date