AUTHORIZATION FOR RELEASE OF CONFIDENTIAL DECEDENT INFORMATION BY THE DELAWARE DIVISION OF FORENSIC SCIENCE

Decedent's Name: _____ Date of Birth: _____ Date of Death: _____

1. I_____, the undersigned, certify that I am the next of kin or the Administratrix/ Executor of the Estate of the deceased (please check one):

   ☐ Next of Kin: I am the_____(state family relationship) of the decedent.

   OR

   ☐ Administratrix/Executor: Provide a copy of your Letter of Appointment.

2. I request the following information for the above named decedent be released to me or to my below named designee at the following address (please initial):

   _____Postmortem Examination Report _____ Postmortem Laboratory Reports _____ Autopsy Report

   Name: _____

   Address: _____

   Phone: _____

   Email: _____

I authorize and request the disclosure of this protected information for the purpose of review and evaluation of the decedent's postmortem records. I understand that this disclosure contains confidential and protected health and private personal information (PPI), and may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by state or federal confidentiality rules. See 45 CFR §164.508(c)(2)(i-iii).

I understand l have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Delaware Division of Forensic Science. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months.

Under penalty of perjury, I represent that I am legally authorized to sign this authorization form for decedent's records.

_____ _____

Signature of Next of Kin or Administratrix/Executor of the Estate Date of Birth

_____ _____

Printed Name Date

Sworn to and subscribed before me this_____day of_____, 20_____in_____County, _____

_____

Signature of Notary (Affix Seal Here)

_____Notary Registration No.

For Internal Use Only by DFS: Last Revised 4/2021

Information verified as the legal next of kin by _____ on _____. _____

DFS Employee Name Date Initials