



Polk County Coroner

Authorization for Use and Disclosure of Protected Health Information

Release TO: Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____

Legal Next of Kin (If different):

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____

Decedent Identification:

Printed Name: _____ Date of Birth: _____
Other Name(s) Used: _____
Last Address: _____
City: _____ State: _____ Zip: _____
Last 4 Digits of Social Security #: _____

Purpose of Request (Must check one):

[] Request of Legal Next of Kin [] Attorney/Legal [] Primary Care Physician [] Hospital Education/Training
[] Other, (specify): _____

I Request the Records be Provided:

[] Paper (hard copy) [] Electronically via email*

Email Address: _____

* Emailed records are subject to encryption.

Information to be Released:

[] All [] Case Report [] Autopsy Report [] Toxicology Report [] Coroner Report
[] Other: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and Communicable/Non-Communicable Diseases

Legal Next of Kin understands if the report(s) contain information in reference to drug and/or alcohol abuse or treatment, psychiatric care, communicable and/or non communicable diseases including but not limited to hepatitis, gonorrhea, syphilis and/or other sensitive information, they agree to its release.

Check One: [] YES [] NO

Form continues on back side.

