Dr. Schultz, MD - President

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Authorization for Release of Information

Location to request from: _____

Street address:_____

Main phone:_____

Dates of care:_____

I, _____, *authorized person,

to the deceased, _____, Date of Birth: _____

give permission to share/discuss medical and case information and autopsy information/results both in written or electronic form and verbally over the phone or in person with Dr. Daniel Schultz, MD and his associates, at Final Diagnosis, Inc. for continuity of care and review for the deceased named above.

Sign: _____ _____

*Authorized next of kin: Executor of estate, Spouse, adult child, parent, sibling Date

Please forward the following specific records when available: (if longer than 50 pages, send in smaller batches)
****Electronic records preferred. Do NOT mail paper records without first confirming we will accept paper.**