Authorization to Release Health Care Information

(22 M.R.S.A. § 1711-C(3) and 45 CFR §164.508(c) (HIPAA))
This authorization complies with both the Maine Statutes and HIPAA requirements.

Anatomical Donor Program

I, ____, have donated my body to the University of New England, College of Osteopathic Medicine ("UNE"), Anatomical Donor Program, for educational, research, and scientific purposes.

By signature below, I understand that and authorize UNE to share my demographic information, such as my name, my date of birth, and my social security number to Hope Memorial Chapel, which Hope Memorial Chapel will use to fulfill its legal obligations with respect to the disposition of my body and the execution of my death certificate. I authorize UNE to provide this information to Hope Memorial Chapel prior to my death.

I UNDERSTAND:

I may revoke all or part of this authorization at any time by executing a written revocation and delivering it to the practitioner or facility holding this authorization, subject to the rights of any person who relied on the authorization before he or she received my revocation. This revocation will be signed and dated by me and will state that all or part of this authorization is revoked.

This authorization shall be effective until revoked by me or another as provided in 22 M.R.S.A. § 1711-C(5) or for 30 months from the date signed, whichever comes first.

A photocopy of this authorization may be used in lieu of the original. .

____ ________________
Signature Date

____
Mailing Address

____ ________________
City, State, Zip Phone

_____________________________________ _______________________________
Date of Birth Social Security Number

____
Name of Primary Care Physician

____
Mailing Address City, State, Zip

____
Telephone #

All medical information will remain confidential and used only for educational, research, and scientific activities.

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