CONSENT FOR THE RELEASE OF MEDICAL INFORMATION
Anatomical Donor Program

Please complete this form only if you are willing to release your medical records at time of death to the Anatomical Donor Program.

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

In order to increase the educational, research, and scientific value of my donation following my death, I authorize and request any health care facility in which I was a patient at any time within two (2) years prior to my death, and any physician who at any time attended me within two (2) years prior to my death to furnish to any representative of the University of New England Anatomical Donor Program, any and all records concerning my case history, treatment and examination which I may have received. I release any such physician or health care facility from any and all responsibility or liability that may arise from this authorization.

____ _________________
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 #

WITNESS 1

____
Printed Name

____
Mailing Address City, State, Zip

____
Signature Date

WITNESS 2

____
Printed Name

____
Mailing Address City, State, Zip

____
Signature Date

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

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1831