

AUTHORIZATION FOR RELEASE OF MATERIALS AND INFORMATION

Name of Patient: _____ Date of Birth: _____

Address: _____

Telephone: _____ Date(s) of Loss(es): _____

I hereby authorize _____ (institution where loss material is stored),

To produce and send H&E recuts from my pregnancy loss(es) and the pathology report(s) to:

**Harvey J. Kliman, MD, PhD
Yale University School of Medicine
Department of Obstetrics and Gynecology
300 George Street, Suite 770
New Haven, Connecticut 06511
203-785-7642**

Please note: We prefer you use FedEx to send this material to us. If the institution will not pay for this service you may be required to pay for the shipping charges. Please discuss this with the Pathology Department when you contact them.

I voluntarily consent to disclose the above information to the person named above. This may include drug and /or alcohol abuse records, mental health records and/or HIV (AIDS) information which may be present in my medical record.

I understand that the refusal to grant consent to release information will not jeopardize my right to obtain present or future treatment.

I understand that this consent may be revoked at any time except to the extent that information has already been released pursuant to this authorization.

Signature of Patient _____ Date _____

Please contact us if you have any questions or concerns about this process:

Kliman Lab Office: 203-785-7642

Dr. Harvey Kliman: 203-785-3854 (harvey.kliman@yale.edu)