



**Ada County Coroner's Office**  
**NEXT OF KIN AND PERSONAL REPRESENTATIVE**  
**RECORDS REQUEST**

**I hereby request information regarding the following person from the Ada County Coroner's Office:**

Name of Decedent: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Death: \_\_\_\_\_

**This information is requested by the following individual:**

Name: \_\_\_\_\_

Relationship to Decedent: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Information Requested:**

\_\_\_\_\_ Autopsy Report/Forensic Inspection (including toxicology)

\_\_\_\_\_ Medicolegal Death Investigator Report

**Purpose:** The above information is being requested from the Coroner's Office to the individual listed above.

**Voluntary Authorization:** I understand that I may refuse to sign this request form.

**Expiration:** I understand that I can revoke this request in writing, but if I do not revoke the request, it will automatically expire two years from the date this form is signed.

**Subsequent Disclosure:** I understand that information may be subsequently used or disclosed by the individual listed above and may no longer be protected by the HIPAA Privacy Rule or the Federal Drug and Alcohol requirements.

**Revocation:** I understand I can revoke my authorization at any time in writing, although any use or disclosure that occurred prior to the date of my revocation is not affected and is only revocable to the extent that the Coroner's Office has not acted in reliance on it.

**Copy:** I understand that I can receive a copy of this completed form.

I understand that this request form extends to the information specified above which MAY INCLUDE information related HIV/AIDS, sexually transmitted disease, behavioral or mental health services, and/or treatment for alcohol/drug abuse. My signature below affirms that I am the legal next of kin and/or personal representative of the deceased person named above.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

\*ADDRESS TO MAIL REPORT(S) IF DIFFERENT FROM ABOVE: