AUTHORIZATION FOR RELEASE OF MATERIALS AND INFORMATION
For Continuation of Patient Care

Name of Patient: _____ **Date of Birth:** _____

Address: _____

Telephone: _____ **Date(s) of Delivery(ies) or Loss(es):** _____

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

To produce and send H&E recuts from ALL blocks (recuts preferred, originals accepted) made from my placentas or losses, any available remaining tissue(s), and the pathology report(s) to:

Harvey J. Kliman, MD, PhD
Yale University School of Medicine
Department of Obstetrics and Gynecology
310 Cedar Street, FMB 225
New Haven, CT 06510
203-785-7642 (Lab Office)
203-737-4397 (Office Fax)

Please note: We prefer the use of a trackable method, such as FedEx or UPS, 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 contact Kliman Labs at 203-785-7642 or kristin.milano@yale.edu for any shipping questions or concerns.

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; kristin.milano@yale.edu

Harvey Kliman, MD, PhD: 203-785-3854; harvey.kliman@yale.edu