CONFIDENTIAL

ILLUME AUTOPSY AND PATHOLOGY SERVICES

Toll Free: (877) 232-9168
Fax: (833) 342-8324
illumepathology@gmail.com

AUTHORIZATION FOR RECORD REVIEW

Decedent's Name: ______________________________, ______________________________
Last First

Date of Birth: ____________________________________

Date of Death: ____________________________________

Sex: ____________________________________

Race: ____________________________________

Hospital and Laboratory contact information: _____________________________________
____

Address: ____

Phone #: ____

Medical History: Please list all known conditions/diseases
PLEASE DO NOT LEAVE BLANK

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ OBESITY ☐ KIDNEY FAILURE

☐ DEMENTIA ☐ LUNG DISEASE ☐ BLEEDING/CLOTTING DISORDER ☐ HIV/AIDS

☐ HEPATITIS ☐ TUBERCULOSIS ☐ OTHER INFECTION:_________________________

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____
____

History of hospitalization/Nursing home or rehabilitation stay

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Reason for record review request by next of kin:

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1. I request a review of records pertaining to postmortem examination and testing of the above named deceased. I authorize Illume Autopsy and Pathology Services, LLC., (Illume), its physicians, staff & authorized personnel to perform the records review, including contacting other facilities to request records or materials Illume deems pertinent to the record review process.

2. I, the undersigned, declare, under penalty of perjury, that I am the legal next of kin of the deceased and therefore have the right to authorize a review of records by ILLUME AUTOPSY AND PATHOLOGY SERVICES.

3. I authorize ILLUME, it's examining pathologist(s) and/or ILLUME staff to engage in performing review of records. I understand that the final results of the examination shall be provided solely and only to the next of kin listed below and that ILLUME does not provide preliminary results.

4. **I hereby authorize the review of the following records:**
Coroner's autopsy report
Coroner's toxicology report
Ascertain Forensics toxicology report
Up to 40 additional pages of medical history or other materials provided for review
and I or my agent also agree to pay fees in the sum of $350.00. If I requested a case consultation with an outside specialist, additional applicable above fees will be applied. I understand and agree that in the event that I send additional medical records to be reviewed in excess of 50 pages, that I will pay for such review at the rate of $180.00 per hour. I understand and agree that the fees for the record review do not include specialized testing such as DNA, genetic, immunohistochemical, or microbiologic studies. In the event additional studies are requested, I understand additional fees shall apply. If requested, additional review of records, preparation for testimony, deposition time, court testimony, and associated travel expenses shall be billed separately and are not included in the cost of the partial autopsy/tissue retrieval. I agree to pay any/all applicable fees prior to services rendered.

5. I understand and agree that after a period of three months immediately following the transmittal of the final report, any remaining tissue samples, fluids, and/or devices, may, without further notice, be made available to medical researcher or be destroyed. I understand that if retained, toxicology specimens and/or samples for DNA/molecular studies may be stored for six months and then shall be destroyed without further notice. I understand that glass slides and histology blocks shall be retained for 7 years.

6. I agree, upon request by an Illume pathologist, to make the deceased's medical records available to ILLUME and I further agree to provide all contact information for each medical provider, upon request. ILLUME hereby agrees that it shall not release the medical records to any third party with the exception of its examining pathologist. The medical records shall be used solely for reference purposes by the examining pathologist and shall be shredded by ILLUME as soon as practical thereafter.

7. In the event I cancel this record review request after submission of this Authorization to ILLUME, I understand and agree that I am responsible for payment of a $75.00 cancellation fee. I agree that in the event I cancel the Authorization after the record review has commenced, I agree to pay ILLUME for all its costs for any/all lost staff time, and/or associated fees.

8. The Authorizing Party (Next of kin signing this Agreement) agrees to defend, indemnify and hold Illume Autopsy and Pathology Services, LLC., its officers, employees, and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees) or claims for damages arising out of or connected in any way to the performance of any part of this Agreement in its entirety.

9. All disputes arising out of this Authorization agreement shall be submitted to mediation in accordance with the rules of Arts Arbitration and Mediation Services, a program of California Lawyers for the Arts. If mediation is not successful in resolving the entire dispute, any outstanding issues shall be submitted to final and binding arbitration in accordance with the rules of that program. If such services are not available, the dispute shall be submitted to arbitration in accordance with the laws of the State of California. The arbitrator's award shall be final, and judgment may be entered upon it by any court having jurisdiction thereof.

10. This "Authorization for Review of Records" agreement shall be construed and interpreted by and under the laws of the State of California. In the event either party enters into civil litigation regarding this agreement, it is agreed by ILLUME and the Authorizing next of kin that such litigation shall be venued in the jurisdiction of the Superior Court of California, in and for Alameda County.

11. This "Authorization for Review of Records" written agreement constitutes the entire agreement between ILLUME and the Authorizing next of kin requesting the service and it supersedes all communications, representations, requests, promises, negotiations, arrangements and agreements, whether oral or written, between the Parties with respect to the subject matter of this Agreement.

Signature of Person Authorizing Partial Autopsy/Tissue Retrieval:

Signature: ____
Date of Signature: _______/__________/________

Printed Name: _____________________________
Address : ____
City : _____________________________, State: __________ Zip: ________
Telephone # : _____________________________
Relationship to Deceased: ____

This Authorization MUST also be signed by a witness:

Witness's signature: ____

Date of Signature: _______/__________/________

PRINTED name of witness: ____

Witness's relationship to decedent: __________________________________

If there are more "next of kin", please have each of them provide their printed name, signature, address, phone number, and relationship to the deceased on this or an accompanying page(s).

Payment Authorization *Check One*

☐ 1. **ZELLE FUNDS TRANSFER TO ILLUME'S ACCOUNT**

- Account is registered as: **illumepathology@gmail.com**

☐ 2. **DIRECT FUNDS TRANSFER TO ILLUME'S ACCOUNT**

- PLEASE CONTACT ILLUME REPRESENTATIVE FOR ACCOUNT INFORMATION

☐ 3. **VENMO FUNDS TRANSFER TO ILLUME'S ACCOUNT**

- PLEASE CONTACT ILLUME REPRESENTATIVE FOR ACCOUNT INFORMATION