



HEALTH CARE

STATEMENT OF AUTHORITY

The undersigned Petitioner (individual requesting the release of information) has requested that the Protected Health Information of _____ (the Decedent), whose date of birth was _____, described in the Patient's Authorization for Release of Protected Health Information be released by McLaren (subsidiary name) _____.

As a condition of McLaren (subsidiary name) _____ granting this request, the Petitioner makes the following statements:

1. I claim that I am authorized to receive the Decedent's medical records because I am:

_____ The Decedent's surviving spouse

_____ The Decedent's surviving adult child

_____ The Decedent's _____ (relationship) AND the Decedent left no surviving spouse or adult child

2. The date and time of Decedent's death

3. Decedent's address at time of death

I, the undersigned Petitioner, will indemnify and hold McLaren (subsidiary name) _____ and its business associate(s) harmless, if by releasing the information now requested by me, McLaren (subsidiary name) _____ and its business associate(s) are made subject to any claim or liability for improper disclosure of records.

I, the undersigned Petitioner, declare that the contents of this Statement of Authority are true to the best of my information, knowledge and belief.

Signature of Petitioner

Date

Printed Name of Petitioner

Telephone Number of Petitioner

Address of Petitioner

