Statement of Authority to Access or Authorize Disclosure of Protected Health Information (PHI) of Deceased Persons

Patient Information	Patient Name: (Print Name) _____ Date of Birth: _____ SSN: _____ MRN: _____
Requestor	Requested by: (Print Name) _____ Address: _____ Phone: _____

Statement Type	**Check ☑ One (One box _must_ be selected and the indicated documents _must_ be provided):**
	
	☐ Certified Copy of the Letters of Testimony or Letters of Administration issued by the court. *Prior to access of the Deceased's medical records, both of the following must be attached.*
	  • Copy of Letters
	  • Death Certificate (patients who did not expire at SCL Health)
	
	☐ No Personal Representative has been appointed to administer the Deceased's estate.
	  1. *Prior to access of the Deceased's medical records, both of the following must be attached.*
	    • Copy of a Legal Document indicating relationship with the deceased, e.g., birth certificate
	    • Death Certificate (patients who did not expire at SCL Health) – AND –
	
	  2. *Complete the following:*
	  Relationship with the Deceased: _____
	
	  How this relationship makes you an heir of the Deceased: _____
	  _____

Signature	Signature: _____ Date: _____
Instructions	**Note:** In the case of a deceased person, state regulations provide that the personal representative appointed by a court to administer the deceased person's estate is the patient's designated representative, and may properly inspect or request copies of the deceased patient's medical records. In situations where no personal representative has been appointed, the heirs of the deceased patient are deemed to be persons who may properly inspect the records and request copies (6 C.C.R. § 1011-1, Ch. II, § 5.1.4.). The heirs of a deceased patient are generally considered to be the patient's next-of-kin and may include a surviving spouse, child, grandchild, parent, sibling, niece, nephew, grandparent, uncle, aunt, or cousin.

SCL Health

O N 1 0 7

Statement of Authority to Access or Authorize
Disclosure of PHI of Deceased Persons

EH-FR-MR-2995-1114

SCL HEALTH USE ONLY

☐ Date Statement Received: _____

☐ Received by: _____

☐ Authorization completed

☐ Copy of letters Attached

☐ Identification #/Driver's License #: _____

Completed by: _____