Deceased Patient Medical Record Release Form

This form is used to request the release of medical records of a deceased patient. Please complete all sections to ensure timely processing. This form is designed for printing and manual signing.

1. Deceased Patient Information

Patient Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Date of Death (MM/DD/YYYY): _____

Social Security Number / Medical Record Number: _____

2. Requestor / Personal Representative Information

Your Full Name: _____

Relationship to Deceased (e.g., Executor, Administrator, Next of Kin): _____

Phone Number: _____

Email Address: _____

Mailing Address: _____

3. Records to be Released

Date Range of Records (e.g., All Records, or Specific Dates): _____

Specific Information to Disclose (e.g., Lab Reports, Discharge Summary, Complete Record): _____

4. Recipient Information

Please specify where the records should be sent:

Recipient Name/Entity: _____

Recipient Address: _____

Recipient Fax (if applicable): _____

5. Authorization and Signature

By signing below, I certify that I am legally authorized to request and receive the medical records of the deceased patient. I understand that proof of authority (e.g., Death Certificate, Letters of Administration, Executor documentation) is required to accompany this form.

Signature of Authorized Representative (Sign after printing): [Sign Here After Printing

Date (MM/DD/YYYY): _____