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Medical Clinic

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MEDICAL RELEASE FORM FOR DECEASED PATIENT

Affidavit

THIS INSTRUMENT HEREBY ACKNOWLEDGES that the undersigned,_____

("affiant") residing at _____

is of legal age, and does hereby swear and affirm that the following is true and accurate, to the best of his/her knowledge, under penalty of perjury:

That I, _____ can state as truth that:

1. I am legally entitled under state law and applicable statues to request medical records for the decease person named:

   _____

2. There is no other person or persons who have legal custody or decision making responsibility for the above named deceased, whatsoever.

3. I am of sound mind.

4. I have not been coached or coerced in any way concerning this testimony and affidavit.

Patient Acknowledgement:

I, _____ (print name) certify that all the information contained in this affidavit is true, correct and complete and made in good faith.

I understand that knowingly making any false statement or representation in this matter may constitute a violation of federal, state, or local statutes, and may result in penalties.

Signature of Patient/Legal Representative		
_____	_____	_____
Signature of Affiant	Date	Relationship to the Patient

STATE OF _____ COUNTY OF: _____

In _____, on the _____ day of _____, 20 _____, before me, a

Notary Public in and for the above state and County _____,
personally appeared known to me or proved to be the person who executed the foregoing instrument, and being first duly sworn, such person acknowledged that he or she executed said instrument for the purposes therein contained as his or her free and voluntary act and deed.

Type of ID Produced: _____ Affiant __ is __ is not personally known to me

_____
NOTARY PUBLIC

My Commission Expires: _____ (SEAL)