

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 Ingham Regional Medical Center.

As a condition of Ingham Regional Medical Center 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  
\_\_\_\_ Surviving Parent (only if there is no surviving spouse and no surviving adult children)  
\_\_\_\_ Surviving Sibling (only if there is no surviving spouse, no surviving adult children, or surviving parent)
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 Ingham Regional Medical Center and its business associate(s) harmless, if by releasing the information now requested by me, Ingham Regional Medical Center and its business associate(s) are made subject to any claim or liability.

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

STATEMENT OF AUTHORITY

