AFFIDAVIT OF AUTHORIZED REPRESENTATIVE DECEASED PATIENT

Patient Name: _____

MRN: _____ DOB: _____

Treatment Location: _____

To be completed by Hospital Staff

The Patient deceased on_____.

Check at least one of the below boxes:

- ❑ A copy of the patient's death certificate is attached.
- ❑ I have confirmed that the patient died at the following MaineHealth organization: _____

To be completed by individual claiming to be the deceased patient's Authorized Representative

Patient Name: _____

Patient Date of Birth: _____

Authorized Representative Name: _____

Authorized Representative Address: _____
_____
_____
_____

Authorized Representative Phone: _____

The patient's estate has no personal representative, executor or administrator, I am the deceased patient's Authorized Representative for release of health care information pursuant to 22 MRSA 1711-C(3-B), because I have the following relationship with the deceased patient (check one):

- ❑ I am the spouse;
- ❑ I am a parent (natural or adopted);
- ❑ I am an adult child, grandchild or sibling (natural or adopted, but not a step-sibling);
- ❑ I am an adult aunt, uncle, niece or nephew, related by blood or adoption;
- ❑ I am an adult related to the patient, by blood or adoption, who is familiar with the patient's personal values; or
- ❑ I am an adult who has special concern for the patient and who is familiar with the patient's personal values

X _____ _____ AM|PM

Signature of Authorized Representative | Date| Time

State of:_____

Then personally appeared the above named _____ to me well known or who provided proof of identity and made oath to the truth of the foregoing before me

Signature: _____

Notary Public/Attorney at Law

Print Name:_____Date:_____Time:_____

My commission expires: _____