DECEASED PATIENT REPRESENTATIVE/HEIR/BENEFICIARY REQUEST

Patient Label

Patient Name	Date of Birth	Telephone Number
Address (Street, City, State, Zip Code)		

Deceased Patient's Date of Death: ___________________________

- **Please provide a copy of the patient's Certificate of Death.**

Michigan law recognizes a patient's right to privacy of their medical information even after their death. If you were the Durable Power of Attorney for Healthcare or Patient Advocate, Michigan law states authority of those positions automatically terminate at the time of the patient's death. If you are the court appointed Personal Representative for the deceased patient, the appropriate Heir at Law, or Beneficiary of the deceased patient's Life Insurance you may request copies of the deceased patient's medical records. Please provide all the information requested on this form.

Requestor Name	Date of Birth	Telephone Number
Address (Street, City, State, Zip Code)		
Relationship to Deceased Patient		

☐ **I am the Personal Representative of the deceased patient named above.**

- **Please provide a copy of the legal document and your driver's license or state ID card.**

☐ **I am a Beneficiary of the Life Insurance policy on the deceased patient named above.**

- **Please provide a copy of the Certificate of Coverage listing you as a named beneficiary and your driver's license or state ID card.**

☐ **I am the Heir at Law of the deceased patient named above. I have consulted with all Heirs at Law (see list describing heirs below) of the patient (if any) and each has agreed they do not object to my getting copies of the deceased patient's medical records. Under Michigan law to qualify as an Heir at Law your relationship with the deceased patient must be through natural birth or adoption, either whole or half-blood. An individual related to the deceased patient only through a step-relationship does not quality as an Heir at Law.**

- **Please provide your driver's license or state ID card.**

☐ **I am the surviving spouse of the deceased patient.**

☐ **I am a surviving descendant of the deceased patient. (e.g. child, grandchild)**

☐ **I am a surviving parent of the deceased patient. (e.g. father, mother)**

☐ **I am a surviving descendant of the deceased patient's parent. (e.g. brother/sister/nephew/niece of the deceased)**

☐ **I am a surviving grandparent of the deceased patient. (e.g. grandfather, grandmother)**

☐ **I am a surviving descendant of the deceased patient's grandparent. (e.g. uncle/aunt/first cousin of the deceased)**

I release Trinity Health from any and all responsibility or liability that may result from release of these medical records.

Signature of Legal Representative/Heir at Law:	**Date:**	**Time:**
License copied - ID Checked / Staff Initials:	**Date:**	**Time:**
Copy of Legal Papers Received:		

Please also complete the Authorization to Use or Disclose PHI form for specific information to be released.