FAIRFIELD MEMORIAL HOSPITAL

AUTHORIZED RELATIVE CERTIFICATION

I, _____ (NAME OF AUTHORIZED RELATIVE) CERTIFY THAT I AM AN AUTHORIZED RELATIVE OF THE DECEASED _____ (NAME OF DECEASED), WHOSE DATE OF BIRTH IS _____.

FOR HIPAA REASONS A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST BE PROVIDED ALONG WITH THIS FORM BY THE AUTHORIZED RELATIVE IN ORDER FOR FAIRFIELD MEMORIAL HOSPITAL TO FULFILL THIS REQUEST.

Initial:

_____ I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT NO EXECUTOR OR ADMINISTRATOR HAS BEEN APPOINTED FOR THE DECEASED'S ESTATE, THAT NO AGENT WAS AUTHORIZED TO ACT FOR THE DECEASED UNDER A POWER OF ATTORNEY FOR HEALTHCARE, AND THE DECEASED HAS NOT SPECIFICALLY OBJECTED TO DISCLOSURE IN WRITING.

_____ I CERTIFY THAT I AM THE SURVIVING SPOUSE OF THE DECEASED.

_____ I CERTIFY THAT THERE IS NO SURVIVING SPOUSE AND MY RELATIONSHIP TO THE DECEASED IS (CIRCLE ONE):

- AN ADULT SON OR DAUGHTER OF THE DECEASED
- EITHER PARENT OF THE DECEASED
- AN ADULT BROTHER OR SISTER OF THE DECEASED

THIS CERTIFICATION IS MADE UNDER PENALTY OF PERJURY. (*NOTE: PERJURY IS DEFINED IN SECTION 32-2 OF THE CRIMINAL CODE OF 1961, AND IS A CLASS 3 FELONY.)

_____ _____ _____

Print Authorized Relative's Name Date Time

_____

Authorized Relative's Signature

Authorized Relative's Address: _____

_____

_____ _____ _____

Witness Signature Date Time

Effective 9-3-2013; Revised 5-20-2014