Northwestern Medicine®

# AUTHORIZED RELATIVE CERTIFICATION TO OBTAIN DECEASED'S MEDICAL RECORDS

I, _____ (print name of authorized relative), certify that I am an authorized relative of the deceased _____ (print name of deceased), date of birth _____/_____/_____.
First Middle initial Last

A certified copy of the death certificate is attached to this certification.

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 health care, and the deceased has not specifically objected to disclosure in writing.

I certify that I am the surviving spouse of the deceased; or I certify that there is no surviving spouse and my relationship to the deceased is (check one):

- ☐ An adult son or daughter of the deceased.
- ☐ Either parent of the deceased.
- ☐ An adult brother or sister of the deceased.

I certify that I am seeking the records as a personal representative who is acting in a representative capacity and who is authorized to seek these records under 735 ILCS 5/8-2001.5 of the Illinois Code of Civil Procedure.

This certification is made under penalty of perjury as defined in 735 ILCS 5/32-2 of the Illinois Criminal Code, which is a Class 3 felony.

Authorized relative's address:

_____

_____

Time _____ Date _____

Authorized relative's signature _____

Print authorized relative's name _____