HEALTH CARE

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 McLaren (subsidiary name) _______________________________.

As a condition of McLaren (subsidiary name) ______________________________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

   ______ The Decedent's _________________________ (relationship) AND the Decedent left no surviving spouse or adult child

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 McLaren (subsidiary name) _____________________ and its business associate(s) harmless, if by releasing the information now requested by me, McLaren (subsidiary name) _________________________________and its business associate(s) are made subject to any claim or liability for improper disclosure of records.

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

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Address of Petitioner