Sparrow

1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Affidavit of Heir or Life Insurance Beneficiary Requesting Medical Records

Under the Michigan Medical Records Access Act, Public Act No. 47 of 2004, an heir or beneficiary of a deceased patient may be entitled to obtain copies of the deceased patient's medical records from a health care provider as defined by the Act (a healthcare provider does not include pharmacists, durable medical equipment suppliers, psychologists, psychiatrists, social workers and mental health providers). If you are requesting copies of a deceased patient's medical records under authority granted by the Michigan Medical Records Access Act as an heir or as a beneficiary of the deceased patient's life insurance policy, please complete the questions below in order to provide sworn testimony supporting your status as an heir of the deceased patient or as a beneficiary of the deceased patient's life insurance policy.

1. Deceased Patient's Name:_____ DOB _____

   Address:_____

   Social Security Number of Deceased patient XXX-XX-_____

2. Name of Requestor: _____ Telephone Number ( ) _____

   Address of Requestor: _____

3. Description of Records requested and dates of service: _____

AFFIDAVIT

I, _____ (insert name of requestor, same name as in Item 2 above), am requesting copies of the medical records described above as an (check one):

- ❒ Heir of the Deceased Patient [Check the box in Section A below that best describes your claim as an heir.]
- ❒ Beneficiary of the Deceased Patient's Life Insurance [Complete Section B on reverse.]

Heir of Deceased Patient

A. I am an heir (either natural, adopted, whole or half-blood) of the Deceased Patient based on the information checked below and I attest that I need a copy of the Deceased Patient's medical records.

1. ❒ I am the **surviving spouse** of the Deceased Patient and I have provided a copy of my driver's license or state ID to verify my identity.
2. ❒ I am an **adult child** of the Deceased Patient, or adult grandchild of the Deceased Patient if such grandchild's parent is deceased. I have provided a copy of my driver's license or state ID to verify my identity.
3. ❒ The Deceased Patient was not survived by a spouse or children. I am the ❒ **mother/** ❒ **father** of the Deceased Patient. I have provided a copy of my driver's license or state ID to verify my identity.
4. ❒ The Deceased Patient was not survived by a spouse, children or parents. I am a surviving sibling (❒ **brother/** ❒ **sister)** of the Deceased Patient, or adult child of such sibling (niece or nephew of the Deceased Patient) if such sibling is deceased. I have provided a copy of my driver's license or state ID to verify my identity.
5. ❒ I am a maternal/paternal grandparent of the Deceased Patient or an aunt or uncle of the Deceased Patient who is also a child of a deceased grandparent. I have provided a copy of my driver's license or state ID to verify my identity.

SPARROW HEALTH SYSTEM

Affidavit of Heir or Life Insurance Beneficiary Requesting Medical Records

6. ❒ I am another person who is an heir of the Deceased Patient under MCL 700.2103, or similar Michigan law; and my relationship to the Deceased Patient is _____ (describe relationship). I have provided a copy of my driver's license or state ID to verify my identity.

I attest that all of the above statements are true to the best of my knowledge and understand that this Affidavit shall be valid only if signed not more than 60 days prior to its submission to Sparrow Health System.

_____
Signature of requestor

_____
Print Name of requestor

Life Insurance Policy Beneficiary

B. I am a beneficiary of the Deceased Patient's life insurance policy. I attest that I need a copy of the Deceased Patient's medical record for the purpose of providing documentation to the life insurer that is examining my claim for benefits under the life insurance policy. I have provided the following to verify my identity:

1. A copy of the Certificate of Coverage listing me as a beneficiary.
2. A copy of my driver's license or state ID.

I attest that all of the above statements are true to the best of my knowledge and understand that this Affidavit shall be valid only if signed not more than 60 days prior to its submission to Sparrow Health System.

_____
Signature of requestor

_____
Print Name of requestor

Notarization of above signature(s):

Subscribed and sworn to before me this _____ day of _____, _____.

_____
_____, Notary Public
_____County, State of Michigan
Acting in _____ County, Michigan
My commission expires: _____

Complete only if requestor signs by use of a mark:

_____
Printed name of witness

_____ _____
Signature of witness Date

_____
Printed name of witness

_____ _____
Signature of witness Date

Sparrow Health System has verified the identification of _____ (requestor's name) by _____ (type of verification, e.g., driver's license or state ID)_____

Verification completed by (Caregiver name and signature) Date