

(Place MR Label Here)

MR#:

Patient's Name:

Patient's Date of Birth:



AFFIDAVIT OF NEXT OF KIN

Patient Name: _____

Patient Date of Birth: _____ Patient Medical Record No. (if known): _____

Facility Name and Address: University of Arkansas for Medical Sciences
4301 W. Markham Street
Little Rock, AR 72205

I, _____, hereby state under oath the following:

- 1. I am the:
 - Spouse
 - Adult Child
 - Grandparent
 - Other _____
 - Parent
 - Adult Brother or Sister
 - Great Grandparent

of _____, a deceased individual (the "patient"), and am therefore the next of kin or otherwise involved in the deceased patient's care and/or payment for care prior to death.

- 2. No executor or administrator has been appointed for the deceased patient's estate.
- 3. I am entitled to receive the deceased patient's protected health information as the next of kin or an individual involved in the deceased patient's care and/or payment for care prior to death.
- 4. I was involved in the patient's care and/or payment for health care prior to the patient's death. Involvement may include visiting the patient, inquiring about the patient, being a family member of the patient, or knowing sufficient details about the patient's circumstances prior to death to indicate involvement in the patient's care prior to death.

Next of Kin/Affiant Address: _____

Next of Kin/Affiant Phone Number: _____

Signature of Next of Kin/Affiant

Date/Time

IN WITNESSES WHEREOF, I have executed this Affidavit on the date set forth below:

Subscribed and sworn to by the foregoing Affiant before me, a Notary Public, on this _____ day of _____, 20_____.

My Commission Expires: _____

NOTARY PUBLIC

(Affix Notary Seal)

