RELEASE OF PERSONAL HEALTH INFORMATION TO PERSONAL REPRESENTATIVE

I/We, ______________________________________ [Name of family member(s)] am/are the
_________________________________________ [Relationship e.g. mother/father, sister,
brother] of __________________________________ [Name of the deceased] (“the deceased”).

I/We have assumed responsibility for administering the deceased’s estate. I am/We are not
aware of any estate trustee(s) or other individual(s) who have responsibility for the
administration of the deceased’s estate.

[ ] As the person representative of the deceased’s estate, I am/We are requesting access to
his/her medical record.

[ ] I/We give our consent to the disclosure of the deceased’s personal health information, as
follows:

______________________________________________________________

Personal Representative(s):

______________________________________________________________

______________________________________________________________

______________________________________________________________

Signature(s):

______________________________________________________________

______________________________________________________________

Date: ________________________________

Form# 7532