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MEDICINE

**THOMPSON**  
HEALTH

**Distributee Certification Form  
Public Health Law Section 18**

This form is to be completed by a relative of a deceased patient who is seeking a copy of the deceased patient’s medical record. Use this form if no Letters of Administration or Letters Testamentary have been issued to any individual as Administrator or Executor of the patient’s estate.

I, \_\_\_\_\_, being first duly sworn, depose and say:

1. I am over 18 years of age.
2. I reside at \_\_\_\_\_
3. I am requesting the medical records of \_\_\_\_\_ (Patient), who has died.
4. I have attached a certified copy of Patient’s death certificate.
5. No Letters of Administration or Letters Testamentary have been issued to any individual as Administrator/Executor of the estate.
6. I am the Patient’s distributee for the following reason:
  - HUSBAND OR WIFE: I was married to the Patient at the time of the Patient’s death.
  - CHILD: I am the Patient’s natural or legally adopted child.
  - GRANDCHILD: I am the Patient’s natural or legally adopted grandchild. My parent, who was the Patient’s natural or legally adopted child, is no longer living.
  - PARENT: I am the patient’s natural or legally adoptive parent. The Patient has no living husband or wife, children, grandchildren or great-grandchildren.
  - BROTHER OR SISTER: I am the patient’s natural or adoptive brother or sister. The Patient has no living parents, husband or wife, children, grandchildren or great-grandchildren.
  - OTHER: I am the Patient’s \_\_\_\_\_.

**The statements I have made are true and accurate to the best of my knowledge. I understand that making a false statement in this document is a felony punishable by imprisonment, fine or both.**

\_\_\_\_\_  
Signature of Requesting Party

Sworn to and subscribed before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public