

ILLINOIS AUTHORIZED RELATIVE CERTIFICATION

Patient Name: _____

Date of Birth: _____

I, _____ (insert name of relative), certify that I am an authorized relative of the deceased _____ (insert name of deceased).

A certified copy of the death certificate must be attached if patient expired outside of a BJC Facility.

I certify that to the best of my knowledge and belief that no executor or administrator has been appointed for the deceased's estate, that no agent was authorized to act for the deceased under a power of attorney for health care, and the deceased has not specifically objected to disclosure in writing.

I certify that I am the surviving spouse of the deceased;

OR

I certify that there is no surviving spouse and my relationship to the deceased is (*check one*):

- An adult son or daughter of the deceased.
- Either parent of the deceased.
- An adult brother or sister of the deceased.

I certify that I am seeking the records as a personal representative who is acting in a representative capacity and who is authorized to seek these records under Section 8-2001.5 of the Code of Civil Procedure.

Signature

Print Name

Address

Date