Patient Identification

Northern Light Health

- ☐ Acadia Healthcare
- ☐ Acadia Hospital
- ☐ A.R. Gould Hospital
- ☐ Blue Hill Hospital
- ☐ C. A. Dean Hospital
- ☐ Eastern Maine Medical Center
- ☐ Home Care & Hospice
- ☐ Inland Hospital
- ☐ Lakewood
- ☐ Maine Coast Hospital
- ☐ Mayo Hospital
- ☐ Medical Transport
- ☐ Mercy Hospital
- ☐ Pharmacy
- ☐ Sebasticook Valley Hospital
- ☐ Work Health

AFFIDAVIT OF AUTHORIZED REPRESENTATIVE DECEASED PATIENT

PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW

***Centralized Health Information Management (HIM) Departments for Northern Light Health include:** Acadia Healthcare/Hospital, A.R. Gould Hospital, Blue Hill Hospital, C.A. Dean Hospital, Eastern Maine Medical Center, Inland Hospital, Maine Coast Hospital, Mayo Hospital, Mercy Hospital and Sebasticook Valley Hospital. **Contact Information: Phone (207) 973-7873 Fax (207) 973-7867**

Other Health Information Management Department Contacts:

	Phone	Fax		Phone	Fax
Home Care & Hospice	(800) 757-3326	(207) 400-8891	Medical Transport	(207) 275-2940	(207) 973-9487
Lakewood	(207) 873-5125	(207) 861-9967	Pharmacy	(207) 275-3216	(207) 561-4804

To be completed by Staff:

Patient's date of death _____ (insert date). Check at least one of the below boxes:

☐ A copy of the patient's death certificate is attached.

☐ I have confirmed that the patient died at the following Northern Light Health member organization: _____ (insert Northern Light Health entity name)

To be completed by individual claiming to be the deceased patient's Authorized Representative:

Patient Name: _____

Patient Date of Birth: _____

Authorized Representative Name: _____

Authorized Representative Address: _____

_____

_____

_____

Authorized Representative Phone: _____

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SCAN TO AFFIDAVIT

The patient's estate has no personal representative, executor or administrator, and I am the deceased patient's Authorized Representative for release of health care information pursuant to 22 MRSA 1711-C(3-B) because I have the following relationship with the deceased patient (check one):

- ☐ I am the spouse;
- ☐ I am a parent (natural or adopted);
- ☐ I am an adult child, grandchild or sibling (natural or adopted, but not a step-sibling);
- ☐ I am an adult aunt, uncle, niece or nephew, related by blood or adoption;
- ☐ I am an adult related to the patient, by blood or adoption, who is familiar with the patient's personal values; or
- ☐ I am an adult who has special concern for the patient and who is familiar with the patient's personal values.

Signed: _____ Date: _____
Authorized Representative

State of: _____ Date: _____

Then personally appeared the above named _____ to me well known or who provided proof of identity and made oath to the truth of the foregoing before me

_____ Print Name: _____
Notary Public/Attorney at Law

My commission expires: _____