Patient Identification

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

AFFIDAVIT OF AUTHORIZED REPRESENTATIVE
DECEASED PATIENT

Page 1 of 3

PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW

<table>
<thead>
<tr>
<th>Phone</th>
<th>Fax</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acadia Healthcare (207) 973-6100</td>
<td>(207) 973-6822</td>
<td>Laboratory (207) 973-6900</td>
<td>(207) 973-6999</td>
</tr>
<tr>
<td>Acadia Hospital (207) 973-6100</td>
<td>(207) 973-6822</td>
<td>Lakewood (207) 873-5125</td>
<td>(207) 861-9967</td>
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<td>A.R. Gould Hospital (207) 768-4175</td>
<td>(207) 768-4060</td>
<td>Maine Coast Hospital (207) 664-5454</td>
<td>(207) 664-5398</td>
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<td>Beacon Health (207) 973-5692</td>
<td>(207) 989-1096</td>
<td>Mayo Hospital (207) 564-4270</td>
<td>(207) 564-4360</td>
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<td>Blue Hill Hospital (207) 374-3458</td>
<td>(207) 374-3971</td>
<td>Medical Transport (207) 275-2940</td>
<td>(207) 973-9487</td>
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<td>C. A. Dean Hospital (207) 695-5225</td>
<td>(207) 695-2254</td>
<td>Mercy Hospital (207) 879-3373</td>
<td>(207) 822-2469</td>
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<tr>
<td>Eastern Maine Medical (207) 973-7873</td>
<td>(207) 973-7867</td>
<td>Pharmacy (207) 275-3216</td>
<td>(207) 561-4804</td>
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<tr>
<td>Home Care &amp; Hospice (800) 757-3326</td>
<td>(207) 400-8891</td>
<td>Sebasticook Valley Hospital (207) 487-4026</td>
<td>(207) 487-3204</td>
</tr>
<tr>
<td>Inland Hospital (207) 861-3150</td>
<td>(207) 861-3158</td>
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Northern Light Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-888-986-6341. If you have a TTY, you may also dial 711 Maine Relay.

If you believe that Northern Light Health or any of its affiliates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language, you can file a grievance with your Northern Light Health Civil Rights Coordinator, 43 Whiting Hill Rd., Suite 200, Brewer, ME 04412, 1-866-769-8363 (telephone), 1-207-989-1420 (fax), or at nondiscrimination@northernlight.org (email). If you need help filing a grievance, your Northern Light Health Civil Rights Coordinator is available to help you.
AFFIDAVIT OF AUTHORIZED REPRESENTATIVE DECEASED PATIENT

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: ____________________________

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: _______________________

Date Reviewed: 6/15/2021 Date Revised: 6/15/2021