MISSOURI AUTHORIZED RELATIVE CERTIFICATION

Patient Name: _____
DOB: _____

I, _____[insert name], certify the following:

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

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

I understand that any disclosures cannot be made if such disclosure is not inconsistent with any prior expressed preference of the deceased patient that is known to the health care provider.

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 (circle one):

(1) The acting trustee of a trust created by the deceased patient alone or with the deceased patient's spouse;

(2) An adult son or daughter of the deceased;

(2) Either parent of the deceased;

(3) An adult brother or sister of the deceased;

(4) A guardian or conservator of the patient at the time of the patient's death; or

(5) A guardian ad litem of the deceased's minor child.

_____
Print Name

_____
Signature

_____
Address

_____
Dated