INOVA

1ROI

For this request to be valid, all items MUST be completed.

Patient Full Name: _____ Patient Date of Birth: _____

Patient Address: _____

My request for medical records for the deceased is based on my relationship as indicated below. Identification of my relationship is required in order to comply with Federal and State privacy laws.

☐ I attest that I am the Personal Representative for the deceased. This means I am the executor, administrator, or other person with authority under applicable law to act on behalf of the decedent or the decedent's estate. I understand that I will need to provide proof of authority with this form.

- OR -

☐ I attest that:

- I am NOT the Personal Representative for the deceased.
- I am not aware of any Personal Representative who has been appointed for the deceased.
- I am only authorized to request information under the following conditions:
  1. I was involved in the deceased's care or payment for their healthcare.
  2. It is not inconsistent with the deceased's prior expressed preferences.
  3. The information in the disclosure is relevant to my involvement in the deceased's care or payment.
- I am one of the following persons (listed below in the order of priority). I certify that there is no other representative of a higher priority than myself. (Check only the applicable boxes.)
  - ☐ 1. Legal guardian or committee of an incompetent or incapacitated patient
  - ☐ 2. Spouse: ☐ Husband ☐ Wife
  - ☐ 3. Adult child: ☐ Son ☐ Daughter
  - ☐ 4. Parent: ☐ Mother ☐ Father
  - ☐ 5. Adult sibling: ☐ Brother ☐ Sister
  - ☐ 6. Any of the other relatives of the patient in the descending order of blood relationship (for example, aunt or uncle); or other person identified by the deceased.

    Specify relationship to the deceased: _____

Representative (signature): _____ Date: _____ Time: _____

Representative (print name): _____

References: Virginia Code Annotated Section 32.1-127.1:03(D)(24)
Health Information and Portability and Accountability Act 1996 (HIPAA) 45 CFR 160.103(2)(iv); 45 CFR 164.502(g)(4); 45 CFR 164.510(b)(5)

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Inova
Right/Access to Medical Records of Deceased Patient

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

CAT # 21099DT / R041123 • PKGS OF 50