LEXARECORDS
Medical Records Management Company
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MEDICAL RECORDS REQUEST FORM (DECEASED PATIENT)

Deceased Patient Name: _____Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of person requesting the records and signing this form: _____

Relationship to Deceased: _____ Phone: _____

Recipient's Name (where are the records being sent):

Name/Organization: _____ Phone: _____

Address: _____ Fax: _____

City/State:_____ Zip Code:_____ E-mail: _____

Reason for Medical Record Request (please check all that apply):

- ☐ Family (Personal)
- ☐ Family (Medical History)
- ☐ Billing/Claims
- ☐ Regulatory Investigation
- ☐ Provider Review
- ☐ Insurance
- ☐ Legal Purpose
- ☐ Law Enforcement
- ☐ Medical Examiner
- ☐ Other _____

Please provide medical records for the deceased patient from the following location for the specified period(s):

☐ Please specify hospital or clinic name: _____ ☐ From: _____ to _____ ☐ All

The following Medical Records are Requested:

- ☐ All health information
- ☐ History/Physical Exam
- ☐ Medications
- ☐ Lab Results
- ☐ Physician's Orders
- ☐ Patient Allergies
- ☐ Operation Reports
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Diagnostic Test Reports
- ☐ EKG/Cardiology Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Radiology Reports & Images
- ☐ Radiation Records
- ☐ Other _____

Your initials are required to release the following sensitive health information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV / AIDS Test Results / Treatment

I hereby represent that I am authorized to request the Deceased Patient's Medical Records (Including any requested sensitive health information as may be indicated above) based upon the following (please check one):

☐ Personal Representative or Legally Authorized Representative (as such terms are defined under the Texas Occ. Code, Texas Health & Safety Code, and the Texas Probate Code) of the deceased patient. (*Please attach copy of: (i) letters testamentary, (ii) letters of administration, (iii) affidavits of heirship, or (iv) some other documentation evidencing the personal representative designation).*

☐ Surviving spouse as shown on death certificate.

☐ Parent, child or sibling of the deceased patient. (*Please attach copy of documentation evidencing the next of kin or heirship relationship.)*

*** If signing as parent, child, or sibling, please certify the following two items by checking the box:**

☐ I certify that there has not been an administration of the decedent's estate, and that no Letters Testamentary or Letters of Administration have been issued by the Clerk of the Court.

☐ I was involved in patient care or paying for patient care in the following manner: _____

_____

Per 45 CFR 164.510(b)(5) A physician may release records to a family member of a deceased individual who was involved in patient care or payment of patient care.

☐ Legal enforcement or other governmental regulatory official and requesting the medical records of the deceased patient in connection with a law enforcement or other government related investigation or audit. (*Please attach a copy of the pertinent law enforcement or governmental regulatory court order requesting a copy of such medical information*.)

☐ A relative of the deceased patient and am requesting a copy of the deceased patient's medical records in connection with a probate matter, will contest or other litigation. *(Please attach documentation evidencing your relationship with the deceased, and the existence of the probate or contest of the Will.)*

I represent that by signing this Medical Records Request Form, I understand and agree with the following:

• Lexa Records has a right to charge a retrieval or processing fee for copies of such Medical Records. I agree to pay Lexa Records the State mandated rates for the requested Medical Record copies.

• I understand that the Medical Records will contain the Protected Health Information (as defined under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") of the deceased patient. I also understand that the Medical Records may contain information about certain sensitive conditions, including: mental health records (excluding "psychotherapy notes"); drug, alcohol or substance abuse records; records or tests relating to HIV/AIDS; and/or genetic diseases or tests (which may be covered under 42 CFR Part 2 or other laws).

• I understand that use of this form and obtaining such deceased patient Medical Records does not exempt the requestor or any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of PHI or other sensitive personal information (e.g., HIPAA or 42 CFR Part 2, restricting the use and/or re-disclosure of such information). Further, in regard to medical records protected by 42 CFR Part 2, such federal rules and applicable state law prohibit you from making further disclosures of such information unless expressly permitted by the written consent of the Personal Representative or Legal Representative of the deceased patient.

*I understand and agree that Lexa Records, its employees and officers, are not responsible or liable for the use, disclosures or re-disclosures by the Requestor or its employees, contractors, agents or representatives as applicable.

*I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

<u>You must sign this form</u>. Also, you must either 1) have your signature notarized OR 2) send in a copy of your driver's license

Authorized Representative Signature: _____ Date: _____
(sign here)

Printed name: _____

This release will expire when the permission is withdrawn, or one year from the date it is signed, or on the following specific date or event: _____.

State of _____

County of _____

This document was signed and acknowledged before me by _____ on the _____ day of _____, 20____.

_____
Notary Public in and for the State of _____