



File #: _____
 Name : _____
 First name : _____

Medical Record Request of a Deceased Patient

IDENTIFICATION OF DECEASED PATIENT

Surname and given name at birth: _____
 Date of birth (Y / M / D): _____ Date of death (Y / M / D): _____

IDENTIFICATION OF APPLICANT

Surname and given name : _____
 Relationship with patient: _____ Telephone No: () _____
 Address: _____
 City: _____ Postal Code: _____

Under what title are you making this request? (Please check one)

Check	Title	Documents attesting Title	Information that may be released*
<input type="checkbox"/>	Spouse	Marriage Certificate + Death Certificate	Cause of Death
<input type="checkbox"/>	Common Law	Income Tax Return (Identification part) + Death Certificate	Cause of Death
<input type="checkbox"/>	Child of Deceased	Birth Certificate of Applicant + Death Certificate	Cause of Death + Hereditary disease
<input type="checkbox"/>	Parent of Deceased	Birth Certificate of Applicant + Death Certificate	Cause of Death + Hereditary disease
<input type="checkbox"/>	Blood Relations (ex : Cousins, Grandparents)	Birth Certificate of Applicant + Birth Certificate of Deceased Patient	Cause of Death + Hereditary disease
<input type="checkbox"/>	Legal Heir	Will + Proof of Last Will & Testament Research	Cause of Death, Information necessary for the exercise of your rights in such capacity
<input type="checkbox"/>	Liquidator of succession	Will + Proof of Last Will & Testament Research	Cause of Death, Information necessary for the exercise of your rights in such capacity
<input type="checkbox"/>	Beneficiary of Insurance Policy	Copy of Insurance Policy or Pension	Cause of Death, Information necessary for the exercise of your rights in such capacity
<input type="checkbox"/>	Other		

I require access to the medical record of the above named deceased patient for the following reason(s). Be specific:

Signature: _____ Date: _____

Witness: _____ Date: _____

