AFFIDAVIT OF PERSONAL REPRESENTATIVE FOR RELEASE OF MEDICAL INFORMATION

STATE OF _____

COUNTY OF _____

NAME OF PATIENT: _____PATIENT'S BIRTH DATE: ___/____/_____

NAME OF PERSONAL REPRESENTATIVE: _____

Under penalty of perjury, I certify the following:

1. I am the person identified above as the Personal Representative of the Patient. I have the following relationship to the Patient. _____
2. The Patient is deceased.
3. (Check the box that applies):

☐ I have been appointed by a court of competent jurisdiction as the executor, administrator or personal representative of the Patient's estate. I attach true and correct copies of court documents verifying my appointment.

☐ The Patient left no will appointing an executor, administrator or other personal representative for the Patient's estate. No probate proceeding concerning the Patient's estate has been initiated. No other person has been appointed as the executor, administrator, or personal representative of the Patient's estate.

4. I have authority to act on behalf of the Patient or the Patient's estate under applicable law. To my knowledge, no other person or entity has a superior right or claim to act on behalf of the Patient or patient's estate under applicable law.

5. I have authority under applicable law to access or obtain copies of the Patient's protected health information. I hereby release Primary Health Medical Group and its affiliated entities, officers, directors, employees, agents and representatives (collectively, "Primary Health Medical Group") from any and all liability related to the release of Patient's protected health information to me or my agents or representatives. I agree to defend, indemnify and hold Primary Health Medical Group harmless against any claim, demand, loss, cost or damage related to Primary Health Medical Group's release of Patient's protected health information to me or per my directions.

SIGNED: _____ DATE: _____ TIME: _____

WITNESS: _____ DATE: _____ TIME: _____