PLACE ON LETTER HEAD

Dear _____,

We have received your request for medical records for _____, "Patient." Washington State law (RCW7.70.065) identifies a statutory priority among individuals that have the authority to consent to the release of an incapacitated Patient's medical records. Before we can release the records to you, we need to confirm that you are eligible to consent to the release.

1. If Patient is under a guardianship, the medical records can only be released with the guardian's authorization. Please check the appropriate statement.

____ I am the Guardian of the Patient and have attached a copy of the Letters of Guardianship, **or**

____Patient did not have a Guardian appointed. Please proceed to item No. 2.

2. If Patient has a durable power of attorney, the medical records can only be released to the attorney in fact named under the power of attorney. Please check the appropriate statement.

____ I am the attorney in fact of the Patient and have attached a copy of the Durable Power of Attorney and all eligible attorneys in fact consent to this release, **or**

____Patient did not have a Durable Power of Attorney. Please proceed to item No. 3.

3. If Patient has a spouse, the medical records can only be released to the spouse. Please check the appropriate statement

____ I am the spouse, **or**

____Patient has no spouse. Please proceed to item No. 4.

4. If Patient has children over the age of 18, the medical records can only be released to a child over the age of 18. Please check the appropriate statement.

____ I am a child of Patient and am over the age of 18 and all children consent to this release, **or**

____Patient had no children. Please proceed to item No. 5.

5. If Patient has a living parent, the medical records can only be released to a parent. Please check the appropriate statement.

____ I am a parent of Patient and all parents' consent to this release, **or**

____Patient has no parent. Please proceed to item No. 6.

6. If Patient has living siblings over the age of 18, the medical records can only be released to siblings over the age of 18. Please check the appropriate statement.

____ I am a sibling of Patient and am over the age of 18 and all siblings consent to this release, **or**

____Patient has no siblings. Please proceed to item No. 7.

7. If Patient has living grandchildren over the age of 18, the medical records can be released to grandchildren over the age of 18 who are familiar with the Patient. Please check the appropriate statement.

____ I am a grandchild of Patient and am over the age of 18, am familiar with the Patient and all grandchildren familiar with the Patient consent to this release, **or**

____Patient has no grandchildren over the age of 18. Please proceed to item No. 8.

8. If Patient has living nieces or nephews over the age of 18, the medical records can only be released to nieces or nephews over the age of 18 who are familiar with the Patient. Please check the appropriate statement.

____ I am a niece or nephew of Patient, am familiar with the Patient and all nieces and nephews familiar with the Patient consent to this release, **or**

____Patient has no nieces or nephews over the age of 18. Please proceed to item No. 9.

9. If Patient has living uncles or aunts over the age of 18, the medical records can only be released to uncles or aunts over the age of 18 who are familiar with the Patient. Please check the appropriate statement.

____ I am an uncle or aunt of Patient, am over the age of 18, am familiar with the Patient and all uncles and aunts familiar with the Patient consent to this release, **or**

____Patient has no uncles or aunts over the age of 18. Please proceed to item No. 10.

10. Patient was not survived by any individual qualified to consent under items one through nine above and I am over the age of 18, have exhibited special care and concern for the Patient, am familiar with the Patient's personal values am reasonably available and willing and able to become involved in Patient's health care and I am not: 1) Patient's physician; 2) the owner, administrator, or employee of a health care facility, nursing home, or long-term care facility where the Patient resides or receives care; or 3) a person who receives compensation to provide care to the Patient.

____ I meet the qualifications required under item No. 11.

The undersigned declares under penalty of perjury of the laws of the State of Washington that the above information is true and correct.

Dated: _____ Signed: _____