(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

AFFIDAVIT OF NEXT OF KIN

Patient Name: _____

Patient Date of Birth: _____ Patient Medical Record No. (if known): _____

Facility Name and Address: University of Arkansas for Medical Sciences
4301 West Markham Street
Little Rock, AR 72205

I, _____, hereby state under oath the following:

1. I am the:
   ☐ Spouse ☐ Adult Child ☐ Grandparent ☐ Other _____
   ☐ Parent ☐ Adult Brother or Sister ☐ Great Grandparent

   of _____, a deceased individual (the "patient"), and am therefore the next of kin or otherwise involved in the deceased patient's care and/or payment for care prior to death.
2. No executor or administrator has been appointed for the deceased patient's estate.
3. I am entitled to receive the deceased patient's protected health information as the next of kin or an individual involved in the deceased patient's care and/or payment for care prior to death.
4. I was involved in the patient's care and/or payment for health care prior to the patient's death. Involvement may include visiting the patient, inquiring about the patient, being a family member of the patient, or knowing sufficient details about the patient's circumstances prior to death to indicate involvement in the patient's care prior to death.

Next of Kin/Affiant Address:
_____

_____

Next of Kin/Affiant Phone Number:
_____

_____ _____
Signature of Next of Kin/Affiant Date/Time

IN WITNESS WHEREOF, I have executed this Affidavit on the date set forth below:

Subscribed and sworn to by the foregoing Affiant before me, a Notary Public, on this _____ day of _____, 20 _____.

My Commission Expires: _____ _____
NOTARY PUBLIC

(Affix Notary Seal)