STATE OF CONNECTICUT
OFFICE OF THE CHIEF MEDICAL EXAMINER
11 Shuttle Rd., Farmington, CT 06032-1939
Telephone: (860) 679-3980 Fax: (860) 679-1257

LEGAL NEXT OF KIN AUTHORIZATION FORM

By completing this form, you are stating that you are the legal next of kin to the deceased, and you are legally authorizing the release of the Medical Examiner's records to the authorized person(s) listed below. You acknowledge that all information provided is true and accurate.

Decedent's Full Name: _____

Date of Death: _____ ME # (if known): _____

Legal Next of Kin:_____ Date Requested: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email: _____

Relationship to Deceased: _____

Authorized Person(s)
to Receive Records: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email: _____

I hereby attest that the information entered on this records request form accurately reflects my relationship with the decedent and my name and contact information. I affirm that this information is accurate and complete to the best of my knowledge. I agree that the use of a typed signature constitutes the legal equivalent of a handwritten signature.

_____
Signature

Please email the completed form to MedicalRecords@ocme.org.
If you have any questions, please email or call 860-679-3980.