

Medical Examiner Records Request

Copies may be obtained by completing this form and emailing it to <u>medicalrecords@ocme.org</u> We will then email you the records when they are complete.

| Name of Agency/Department: | |
|--|-----------------|
| Your Case/ID #: | Date Requested: |
| Person requesting Records/Title: | |
| Address: | |
| City: State: | Zip Code: |
| Telephone # | Fax# |
| Email for where records are to be sent: | |
| Types of records requested: | |
| Decedent's Full Name: | |
| Date of Death: | ME# (if known): |
| If you have any questions please email us at <u>medicalrecords@ocme.org</u> or call us at OCME- 860-679-3980 and ask for medical records. Additional information can be found on our Website: <u>https://portal.ct.gov/OCME</u> | |