
 UTAH DEPARTMENT OF HEALTH State of Utah  Office of the Medical Examiner	Phone: 801-816-3850 Fax: 801-964-1240 Web: ome.utah.gov Chief Medical Examiner Erik Christensen, M.D.	<h2 style="margin: 0;">RECORDS REQUEST FORM</h2> Mail to: Utah Office of the Medical Examiner 4451 South 2700 West Taylorsville, UT 84129
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DECEDENT INFORMATION	
NAME: _____	
BIRTH DATE: _____	OME CASE # (IF KNOWN): _____
DATE of DEATH: _____	

TYPE OF RECORDS REQUESTED	
* Some fees may apply. Make check/money order payable to: Utah Medical Examiner's Office	
<input type="checkbox"/> AUTOPSY/TOXICOLOGY REPORT	<input type="checkbox"/> OTHER (SPECIFY): _____

SEND REQUESTED MATERIAL TO	RELATIONSHIP: <input type="checkbox"/> NEXT OF KIN <input type="checkbox"/> LEGAL AGENCY <input type="checkbox"/> INSURANCE AGENCY <input type="checkbox"/> OTHER (SPECIFY): _____
	AGENCY: (IF APPLICABLE)
	NAME:
	<input type="checkbox"/> Mail to: <input type="checkbox"/> Fax to: _____ <input type="checkbox"/> Picked up in Person
	ADDRESS:
	CITY, STATE, ZIP:

NEXT OF KIN AUTHORIZING REQUEST	<input type="checkbox"/> CURRENT SPOUSE <input type="checkbox"/> SIBLING <input type="checkbox"/> CHILD (18+) <input type="checkbox"/> PARENT <input type="checkbox"/> GRANDPARENT <input type="checkbox"/> GRANDCHILD (18+) <input type="checkbox"/> LEGAL GUARDIAN (ATTACH DOCUMENTATION) <input type="checkbox"/> OTHER (SPECIFY): _____	
	NAME: _____	
	PHONE #: _____	EMAIL: _____
	SIGNATURE: _____	DATE: _____

FORM MUST BE NOTARIZED AND RECEIVED IN-OFFICE WITHIN 90 DAYS	
STATE OF: _____	
COUNTY OF: _____	
Subscribed and sworn before me this _____ day of _____, 20____	
_____ NOTARY PUBLIC My Commission Expires: _____	
(SEAL)	

The records maintained by the Office of the Medical Examiner are classified confidential and any release shall be consistent with the provisions of Utah Code Ann. § 26-4-2 (3); 26-4-17 (2) and (3)