



CLARK COUNTY WASHINGTON

clark.wa.gov/medical-examiner

MEDICAL EXAMINER

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Date of request: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL REPORTS – INSURANCE COMPANY

Name of decedent: _____

I, _____, declare under penalty of
(Name of requesting party)
perjury and the laws of the State of Washington that the foregoing is true and correct. As the personal representative or family member of the decedent, I hereby authorize the Clark County Medical Examiner’s Office to send a copy of the confidential autopsy, toxicology and investigative reports to the insurance company listed below. I understand that pursuant to Washington Statute R.C.W. 68.50.105, the information contained in the aforementioned reports is confidential.

Release reports to: _____

Mailing Address or Email Address _____

Pursuant to Washington Statute R.C.W 68.50.105, the term "family" means the surviving spouse, state registered domestic partner or any child, parent, grandparent, grandchild, brother or sister of the decedent, or any person who was guardian of the decedent at the time of death.

Relation to decedent: _____

Address of requesting party: _____

I authorize the release of this report(s) freely, voluntarily and knowingly.

DATED this _____ day of _____, 20____ in the city/town of _____ the state of _____.

Requesting party signature

Witness signature
(Notary or Medical Examiner staff)

Original document to Medical Examiner, copy or fax will not be accepted.