



proud past, promising future

CLARK COUNTY
WASHINGTON

Date of Request: _____

REQUEST FOR CONFIDENTIAL REPORTS

Name of Decedent: _____

I, _____, declare under penalty
(Name of Requesting Party)
of perjury and the laws of the State of Washington that the foregoing is true and correct. As an authorized family member or personal representative of the deceased I hereby request the Clark County Medical Examiner's Office send a copy of the confidential investigative, autopsy and toxicology report (if performed) to my address listed below. I understand that pursuant to Washington Statute R.C.W 68.50.105 the information contained in the aforementioned reports is confidential.

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: _____

I authorize the release of 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)