



proud past, promising future

CLARK COUNTY
WASHINGTON

OFFICE OF THE MEDICAL EXAMINER
Dennis J. Wickham · Medical Examiner

Date of request: _____

REQUEST FOR CONFIDENTIAL REPORTS - FAMILY

Name of decedent: _____

I, _____, declare under penalty
(Name of requesting party)
of perjury and the laws of the State of Washington that the information provided herein
is true and correct. As an authorized family member or personal representative of the
decedent, I hereby request the Clark County Medical Examiner's Office send a copy of
the confidential investigative, autopsy and toxicology reports (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)