McLaren
HEALTH CARE

DECLARATION OF MEDICAL INDIGENCY AND ACKNOWLEDGEMENT OF RECEIPT OF RECORDS BY PATIENT/AUTHORIZED REPRESENTATIVE

I hereby certify and acknowledge the following information as true to the best of my knowledge and belief:

- I understand that the federal and state laws allow a health facility to charge a fee for these records; however, any otherwise applicable fees must be waived for a medically indigent individual;
- I understand that a "medically indigent individual" is defined, in part, as an individual receiving family independence program benefits, supplemental security income, or state supplementation;
- I certify that I am presently a "medically indigent individual," pursuant to my receipt of the following benefits: _____
- I understand that the health facility from which I have requested records may require that I provide proof that I am a recipient of the assistance described above to confirm my status as a "medically indigent individual".
- I further understand that if it is confirmed that I am a "medically indigent individual," I am limited to one free set of copies of my records from the above-referenced health facility and that any additional requests for the same records from the same health facility are subject to the fee provisions under state and federal law;

Patient Requests:

- I requested the (1) free copy of medical records for the following dates of treatment_____.

_____	_____	_____
Patient Signature	Date	Witness

Representative Requests:

- I requested the (1) free copy of medical records for the following dates of treatment_____be given to_____

I declare the above to be under penalty of perjury,

_____	_____	_____
Patient Signature	Date	Witness

Revised 3/8/22