

**IN THE PROBATE COURT OF CLERMONT COUNTY, OHIO  
JAMES A. SHRIVER, JUDGE**

**In the Estate of** \_\_\_\_\_, **Deceased**

**Case No.** \_\_\_\_\_

**APPLICATION TO RELEASE MEDICAL RECORDS AND MEDICAL BILLING  
RECORDS (R.C. 2113.032)**

Now comes \_\_\_\_\_ the \_\_\_\_\_ of the above  
(Name) (Relationship)  
named decedent who died \_\_\_\_\_ and resided at \_\_\_\_\_  
(Date of Death)

\_\_\_\_\_ whose last four (4) digits  
of their social security number is \_\_\_\_\_, and hereby requests authority to release  
medical records and medical billing records for the decedent from the following medical  
providers that provided medical care or treatment to the decedent for the limited purpose of  
deciding whether or not to file a wrongful death, personal injury, or survivorship action:

---

---

---

---

---

---

---

---

---

---

Applicant further states the following:

\_\_\_\_ Applicant is an individual who is eligible to be appointed as a personal representative of the  
above named decedent's estate under Ohio law; or

\_\_\_\_ Applicant is named as executor in the above named decedent's will, and Applicant has filed  
a copy of decedent's will within this Application.

Applicant has attached Form 1.0 – Surviving Spouse, Children, Next of Kin, Legatees and Devisees.

Applicant acknowledges that an order shall not be issued until ten days following the Court's transmission of a copy of this application to those persons listed on the Form 1.0 who have not filed a signed Waiver of Notice/Consent.

\_\_\_\_\_  
Attorney for Applicant  
(Registration Number \_\_\_\_\_)

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Typed or Printed Name

\_\_\_\_\_  
Typed or Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Telephone Number (include area code)

\_\_\_\_\_  
Telephone Number (include area code)