**Hospital Name:** [Your Hospital's Name]

**Date:** [Date of the Declaration]

**Patient Information:**

* **Patient's Name:** [Patient's Full Name]
* **Date of Birth:** [Patient's Date of Birth]
* **Gender:** [Patient's Gender]
* **Address:** [Patient's Address]
* **Medical Record Number:** [Patient's MRN, if applicable]
* **Social Security Number:** [Patient's SSN, if applicable]

**Declaration:**

I, [Your Name], as an authorized representative of [Hospital's Name], hereby declare the following information regarding the patient identified above:

1. **Admission and Discharge:**
   * The patient was admitted to [Hospital Name] on [Date of Admission].
   * The patient was discharged from [Hospital Name] on [Date of Discharge].
2. **Cause of Admission:**
   * The patient was admitted for the following medical condition(s): [List the medical condition(s) or reason(s) for admission].
3. **Medical Treatment and Procedures:**
   * During the hospitalization, the following medical treatments and procedures were performed: [List the treatments and procedures, if applicable].
4. **Condition at Discharge:**
   * At the time of discharge, the patient's medical condition was as follows: [Describe the patient's condition at the time of discharge, e.g., stable, improved, etc.].
5. **Cause of Death (if applicable):**
   * If the patient has deceased during the hospitalization, please specify the cause of death: [Specify the cause of death, if applicable].
6. **Deceased Patient Information (if applicable):**
   * If the patient has deceased, please provide the following information:
     + Date and time of death: [Date and Time of Death]
     + Location of death: [Specify where the patient passed away, e.g., within the hospital, at home, etc.].

**Authorized Signature:** [Your Signature]

**Title/Position:** [Your Title or Position at the Hospital]