Please print on Organization Letterhead.

Certification of Data Destruction

I, _____ representing

(Name of Custodian)

_____ certify that the following

(Name of Organization)

Health Services Cost Review Commission data records have been destroyed. (Please identify destruction method)

_____

MD Hospital Discharge Data Years

Other

_____

This Certificate of Destruction closes the corresponding Data Use Agreement(s).

_____

Organization Name

_____

Requestor/Appointed Authority (printed name)

_____

Requestor/Appointed Authority (signature)

_____

Date