ORDER FOR RELEASE OF REMAINS

TO: MEDICAL EXAMINER, COUNTY OF SAN DIEGO

RE: REMAINS OF _____, ME CASE # _____

I certify that pursuant to the State of California Health & Safety Code, Section 7100, it is my legal right to control the disposition of the remains referenced above, the location and conditions of interment, and arrangements for funeral goods and services to be provided. I further certify that I am acting in the capacity of: **Legal Next of Kin**_____, **OR Executor/Executrix** _____, **OR Agent with Durable Power of Attorney for Health Care** (must be for Health Care) _____ **OR other legal capacity** _____ (please **INITIAL** the appropriate category). If acting in a capacity other than Legal Next of Kin, I have attached a copy of the relevant appointing document(s).

I acknowledge that, pursuant to the State of California Government Code Sections 27472 and 54985 and Resolution No. 03-086 of the Board of Supervisors, County of San Diego, I may be liable for Medical Examiner fees of $173 for transportation ($153) and body pouch ($20) and agree to pay said fees promptly if invoiced. _____ (please **INITIAL**).

Therefore, upon completion of your examination of the deceased please release the remains referenced above to the custody of the service designated below. If possible please **RELEASE** _____ **OR DO NOT RELEASE**_____ (please **INITIAL** desired choice) all of the deceased's personal property in your care with the remains. I understand that personal property can only be released during regular working hours (M-F 8-5, except holidays).

_____

Print Name of Designated Mortuary, Cremation Society, or other Disposition Service

_____ _____

Print Name of Person Signing Relationship | Signature Date Signed

_____ _____

Mailing Address of Person Signing | Phone #

_____ _____

City, State, Zip Code of Person Signing | City, State Where Signed

DECEDENT INFORMATION					
Name of Deceased – First (Given)	Middle	Last (Family)		Gender	Date of Death
Date of Birth	Age	Place of Birth	Social Security Number	Race	
Marital Status	Occupation	Residence Address:			

FOR MEDICAL EXAMINER DEPARTMENT USE ONLY

Fees Waived:

14 & Under _____

Criminal Act of Another _____

Indigent _____

Other _____

Manner of Payment

Receipt # _____ PA _____

Mortuary _____ Active Duty Military _____

Other _____

Person Executing This Order For Release _____

ME FAA License # _____ Rev. 3/10/09