

COUNTY OF SAN DIEGO MEDICAL EXAMINER

5570 OVERLAND AVENUE, SUITE 101, SAN DIEGO, CA 92123-1215
PHONE: 858-694-2895 FAX: 858-495-5956

ORDER FOR RELEASE OF REMAINS

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 (please **INITIAL** the appropriate category):

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** _____. If acting in a capacity other than Legal Next of Kin, I have attached a copy of the relevant appointing document(s). 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 decedent's personal property in your care with the remains. I understand that personal property can only be released during regular working hours (M-F 1:00-4:30, except holidays). **As per California Laws and Department Policies, if the property in custody of the Medical Examiner's Department is not collected within 60 days from the date of death, it will be processed for immediate disposal.**

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 Home / Cell Phone Number

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

					WEIGHT:		
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:				

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MEDICAL EXAMINER DEPARTMENT USE ONLY

ME FAS _____ Release Date/Time: _____
Transport Staff: _____ Printed Name: _____
(signed)