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 Signed | Relationship | Signature | Date

____

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 ____

ME FAA License # ________

Manner of Payment

Receipt # ________ PA ________

Mortuary ________ Active Duty Military ________

UCSD ________ Other ________

Person Executing This Order For Release ________

Rev. 04/18/08