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

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).

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). **As per California Laws and Department Policies, if the property in custody of the Medical Examiner's Department is not collected within 90 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

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:		

MEDICAL EXAMINER DEPARTMENT USE ONLY

ME FAS _____ Release Date/Time: _____

Transport Staff: (signed) _____ Printed Name: _____