COUNTY OF SAN DIEGO MEDICAL EXAMINER

5570 OVERLAND AVENUE, SUITE 101, SAN DIEGO, CA 92123-1206 PHONE: 858-694-2895

ORDER FOR RELEASE OF REMAINS

TO: MEDICAL EXAMINER, COUNTY OF SAN DIEGO

attached a copy of the relevant appointing document(s).

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

I acknowledge that, pursuant to the State of California Government Code Sections 27472 and 54985 and Ordinance No. 10151 of the Board of Supervisors, County of San Diego, I may be liable for Medical Examiner fees of \$280 for transportation (\$245) and body pouch (\$35) and agree to pay said fees promptly. _____ (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

Mailing Address of Person Signing

City, State, Zip Code of Person Signing

City, State Where Signed

Date Signed

| DECEDENT INFORMATION | | | | | | | | | | | | |
|--|---------------------------|-----|--------------------|----------|---------|------------------------|---|-------|------|---|--|--|
| Name of Deceased - First (Given) | | | Middle | | | Last (Family) | | Gende | r | Date of Death | | |
| | | | | | | | | | | | | |
| Date of Birth Age | | Age | • | Place of | f Birth | Social Security Number | | er | Race | | | |
| | | | | | | | | | | | | |
| Marital Status | Marital Status Occupation | | Residence Address: | | | | | | | | | |
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| MEDICAL EXAMINER DEPARTMENT USE ONLY | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Manner of Payment | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Person Executing This Order For Release Bill Mortuary Mortuary Pre-Pay | | | | | | | | | | | | |
| Active Duty MilitaryPAUnder 14Family Requested Autopsy Other | | | | | | | | | | | | |
| | | | | | | | | | | | | |

Rev. 07/14/2011

Relationship

Signature

Phone #