AUTHORIZATION TO RELEASE

Decedent: _____ Date of Death:_____

Age: _____ Race/Ethnicity: _____ Sex:_____ DOB:_____ ME Case No:_____

I certify that I am the "legally authorized person"*, and do hereby authorize the Office of the Medical Examiner, District 19, Florida to release the remains of the above decedent to:

_____ Funeral Home/Crematory.

Signature of legally authorized person:_____ Print: _____

Relationship:_____ Date: _____ Time: _____

Address:_____ Phone: _____

Witness:_____

Funeral home/crematory representative:_____Date:_____Time:_____

*__Legally Authorized Person"__ means, in the priority listed below **(**per Florida Statute 497):

I. __Next of kin__:
1. Spouse
2. Adult Child (if no spouse)
3. Parent (if no spouse or children)
4. Adult Brother/Sister (if no 1,2,3)
5. Adult Grandchild or Grandparent (if no 1,2,3,4)
6. Next Degree of Kinship: _____

II. __Person at time of death when there is no family:__
1. Guardian
2. Personal Representative
3. Attorney in Fact
4. Health Surrogate
5. Public Health Officer
6. Representative of Nursing Home or Health Care Facility
7. Friend Assuming Responsibility

RELEASE INFORMATION

Removal Date: _____ Time: _____ Valuables Received: Yes ___ No ___

Funeral Home: _____ Representative: _____

Revised 9/2016