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

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 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).

Featheringill Mortuary
Print Name of Designated Mortuary, Cremation Society, or other Disposition Service

Print Name of Person Signing	Relationship	Signature	Date Signed
		X	

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:			

MEDICAL EXAMINER DEPARTMENT USE ONLY

Manner of Payment

Person Executing This Order For Release _____ Bill Mortuary _____ Mortuary Pre-Pay _____

Active Duty Military ____ PA ____ Under 14 ____ Family Requested Autopsy _____ Other _____

ME FAS _____

Rev. 07/14/2011