

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).

Cremation Society of Orange Coast 12425 Lewis St. #102, Garden Grove, CA 92840 (714) 740-2762
(714) 740-2764 Fax

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 _____ 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