OFFICE OF THE DISTRICT ONE MEDICAL EXAMINER

Pensacola Fax: (850) 285-0774

CONSENT FOR BODY RELEASE ML_____

The District One Medical Examiner is hereby given permission to release the body of:

Decedent's Name: _____ Decedent's Date of Birth: _____

Funeral Home Name & Location (City) _____
Funeral Home Telephone: _____

The undersigned represents that:
1. Pursuant to Florida State Statute 497.005, I am defined as a legally authorized person who has the right to direct a funeral home to dispose of the decedent's remains in a manner prescribed by law.

2. To the best of my knowledge, I am not aware that the decedent, in any legal document, declared his or her wishes to will their remains to any person, entity or funeral home.

3. I have provided the Medical Examiner with all known information, which could identify or locate a higher class living relative and understand if the priority of consent classification of which I am a member, contains more than one person, or a higher-class relative who objects or may object to the release of the decedent by the Medical Examiner, that I must make such objection known to the Medical Examiner prior to the release of the decedents remains.

4. If the decedent is unclaimed pursuant to Florida State Statute 406.50(4) and I am not the spouse of the decedent, I swear and affirm that I am not aware of any other person, who has an equal or greater legal interest or claim to the decedent's remains than I.

5. To the best of my knowledge, the decedent was not an active duty or reservist service member with any branch of the United States Armed Forces.

6. I hereby release the District One Medical Examiner's Office and the County, their agents, employees or representatives from any and all liability which may result or arise out of the release of the said decedent and as such hereby accept sole liability and financial responsibility for any action filed against the District One Medical Examiner for the release of the decedent to the person, entity or funeral home I have selected.

_____ _____
Print Name (Legally Authorized Person) Relationship to Decedent

_____ _____
Street Address City, State, Zip Code

_____ _____
Legally Authorized Person Telephone Signature (Legally Authorized Person)

_____ _____
Witness Name Date

Legally Authorized Person: (Priority of Consent)
1. Self – Will or Prearrangements
2. Military – Form DD93
3. Spouse
4. Adult Son or Daughter
5. Parent
6. Adult Brother or Sister
7. Other Blood Relative
8. Judicially Appointed Guardian
9. Personal Representative (Estate)
10. Public Health Officer

**** Important Legal Information ** Any person who knowingly fails or refuses to report information pertinent to a death investigation by the Medical Examiner shall be guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.**