

**AUTHORIZATION TO RELEASE REMAINS**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Place Patient Label**

Authorization-P  
Authorization to Release Remains



IDN13150081

It is the responsibility of the family member to contact the funeral home of choice to make funeral arrangements.

The funeral home I have selected is: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Telephone: \_\_\_\_\_

I authorize the above funeral home to remove the remains of my (relationship to deceased):

\_\_\_\_\_

Signature of next of kin: \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature of Chaplain \_\_\_\_\_