

Edgley Cremation Services, Inc.

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Release Authorization

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: _____