



Authorization for Release and Removal with Embalming

To:
 Name of Hospital, Nursing Home, ME/Coroner Address, City, State, Zip Code

Name of Deceased Person Date of Death

The undersigned hereby represents that I am of the (we are of the same and) nearest degree of relationship to the above-named deceased person. I am (We are) legally authorized or charged with the responsibility for the proper burial and/or other disposition of the remains of the above-named deceased person.

The undersigned individually and jointly and severally authorize the release of the remains of the deceased person and any personal property or effects belonging to the deceased person to the above-named funeral home and further authorize said funeral home to remove the remains of the deceased person to its premises.

Back Protection Inc retains the right to hold electronic verification of the remains of the deceased, and I agree that the Back Protection Inc may have access and use photographic and electronic images of the deceased and any medical records of the deceased, for identification and training purposes.

X
Next of Kin

Address

City, State, Zip Code

Phone

Email

Funeral Home

Address

City, State, Zip Code

Phone

Fax

Email