



BEXAR COUNTY MEDICAL EXAMINER'S OFFICE
RANDALL E. FROST, M.D.
CHIEF MEDICAL EXAMINER

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(210) 335-4011 FAX (210) 335-4091 or (210) 335-4021

AUTHORIZATION TO RELEASE REMAINS

TO: Bexar County Medical Examiner's Office

FROM: Heart of Texas Cremation & Burial Service
(Funeral Home Name)

DATE: _____

I, _____, hereby certify and represent that I am the _____
(Print Name) (Relationship to decedent)

and legal next of kin of:

_____, AKA _____
(Name of Decedent as it appears on Social Security Card or birth certificate)

_____, _____
(Date of Birth) (Social Security Number if applicable)

I, the undersigned, further agree to hold the Bexar County Medical Examiner's Office harmless of any liability on account of the said authorization.

It is my desire and request that you release the personal effects and the remains of the decedent to

Heart of Texas Cremation & Burial Service
(Name of Funeral Home)

Signature of Next of Kin: _____ Relationship _____

Address: _____

Telephone Number: _____

Witnessed by: _____ Date: _____