Northern Regional Medical Examiner's Office

Release of Remains and Removal Authorization Form

NAME OF DECEDENT *(first, middle, last)*		TODAY'S DATE
DATE OF DEATH	AGE	SEX
PLACE OF DEATH		
NAME OF FUNERAL HOME *(As Authorized by Agent)*		
NAME OF MANAGER		NJ LICENSE NO.
NAME OF FUNERAL HOME REPRESENTATIVE *(if not the Manager)*		

The term "Authorizing Agent" or "Authorizing Agents," used throughout, refers to the individual or individuals retaining the right to control disposition as established by N.J.S.A. 3B:10-21.1 and N.J.S.A. 45:27-22. Authorizing Agent(s) may include an appointed funeral agent named in a decedent's will, an individual so appointed by a court of competent jurisdiction, and/or an individual meeting the criteria set forth by N.J.S.A. 45:27-22.

Authority of Authorizing Agent(s)

☐ The decedent was an active duty military service member who died while on active duty and has authorized the individual listed on the decedent's United States Department of Defense Record of Emergency Data, DD Form 93, or its successor form, to control the funeral and disposition of the decedent, as provided by N.J.S.A. 45:27-22.

Name _____

☐ The decedent has appointed an authorized funeral agent in a will as provided by N.J.S.A. 3B:10-21.1 and N.J.S.A. 45:27-22.

Name _____

(If no funeral agent is designated, proceed to Authority of Authorizing Agent(s), as established by N.J.S.A. 45:27-22, below.)

☐ I/We hereby certify that the following individual(s) may claim the right to control the funeral and disposition of the decedent as an Authorizing Agent(s), as set forth by N.J.S.A. 45:27-22:

Spouse, civil union partner or registered domestic partner. ☐ Yes ☐ No *(Separated spouses **should** be listed. Divorced former spouses **should not** be listed.)*

Name: _____

If no spouse, civil union partner or registered domestic partner, proceed to biological and legally adopted children of the deceased.
*(**Do not** include step-children. Additional names may be attached, with complete information, on a separate sheet.)*

Children over 18 years old? ☐ Yes ☐ No List Names: _____

How many? _____ Name: _____

Name: _____

Name: _____

If no children over 18 years old, proceed to biological or legally adoptive parents of the deceased. *(**Do not** include step-parents.)*

Parent(s)? ☐ Yes ☐ No List Names: _____

How many? _____ Name: _____

If no parents, proceed to siblings. List biological siblings and those related by adoption.
*(**Do not** include step-brothers or step-sisters. Additional names may be attached, with complete information, on a separate sheet.)*

Sibling(s)? ☐ Yes ☐ No List Names: _____

How many? _____ Name: _____

Name: _____

Name: _____

If no siblings, state name and relationship of authorizing party.

Name: _____ Relationship to Decedent: _____

I/We certify that I am/we are related as stated above, have charge of the body and as such possess full legal authority and power, according to the laws of the State of New Jersey to authorize the release the remains from the Northern Regional Medical Examiner's Office to the named agent, as a representative of the above named Funeral Home.

In addition, I am/we are aware of no objection to this removal of remains and transfer of custody to the Funeral Home by any spouse, civil union or registered domestic partner, child, parent, or sibling specified, whose right to control disposition supersedes mine/ours as established by N.J.S.A. 45:27-22. **Initial** _____

Indemnification

As the Authorizing Agent(s), I/we hereby agree to indemnify, defend, and hold harmless the Northern Regional Medical Examiner's Office, its officers, agents and employees or the Funeral Home, its officers, agents, and employees of and from any and all claims, demands, causes of action, and suits of every kind, nature and description, in law or equity, including any legal fees, costs, and expenses of litigation, arising as a result of, based upon or connected with this authorization, including any claims brought by any other person(s) claiming the right to control the disposition of the decedent, or any other action performed by the Northern Regional Medical Examiner's Office, its officers, agents or employees or the Funeral Home, its officers, agents, or employees, pursuant to this authorization, excepting only acts of willful negligence.

Signature of Authorizing Agent(s)

By executing this form, as the Authorizing Agent(s), the undersigned warrant that all representations and statements contained on this form are true and correct, that these statements were made to induce the Northern Regional Medical Examiner to release the remains of the named decedent to the named agent representing the Funeral Home, and that the undersigned have read and understand the provisions contained in this form, acknowledging and agreeing with every provision initialed by the principal authorizing agent.

Executed this _____ day of _____ 20_____.

NAME	SIGNATURE	DATE
ADDRESS		
TELEPHONE NUMBER	RELATIONSHIP TO DECEDENT	

NAME	SIGNATURE	DATE
ADDRESS		
TELEPHONE NUMBER	RELATIONSHIP TO DECEDENT	

NAME	SIGNATURE	DATE
ADDRESS		
TELEPHONE NUMBER	RELATIONSHIP TO DECEDENT	

Medical Examiner's Office Only

The body of the named decedent has been released in accordance with this authorization.

Name of Funeral Director as Witness

Name of ME Office Representative

Signature of Funeral Director as Witness Date

Signature of ME Office Representative Date