



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

7337 Louis Pasteur Drive, San Antonio, Texas 78229-4565  
(210) 335-4011 FAX (210) 335-4091 or (210) 335-4021

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**AUTHORIZATION TO RELEASE REMAINS**

TO: Bexar County Medical Examiner's Office

FROM: aCremation  
(Funeral Home Name)

DATE: \_\_\_\_\_

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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

aCremation  
(Name of Funeral Home)

Signature of Next of Kin: \_\_\_\_\_ Relationship \_\_\_\_\_

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

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

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_