

Rhode Island Department of Health
Office of State Medical Examiners



RELEASE AUTHORIZATION FORM

Decedent Release Authorization

I, _____, authorize the Rhode Island Office of State Medical Examiners to
(Undersigned)

release the body of _____, my _____, along
(Name of Decedent) (Relationship to decedent)

with their personal belongings to _____ at
(Name of Funeral Home)

_____ and/or its agents. I hereby certify that
(Address of Funeral Home, City/Town, State, ZIP Code)

I am legally authorized or charged with the responsibility for such burial and/or other disposition.

Signature

Date

Home Address

City/Town, State, ZIP Code

Phone Number (Include area code)

WITNESS:

Signature

Date

A COPY OF THE SIGNED RELEASE AUTHORIZATION WILL SERVE AS A RECEIPT

**** Decedents are only released Monday - Friday, 8:30 a.m. - 12:00 noon and 2:00 p.m. to 4:15 p.m. ****