# HENNEPIN HEALTHCARE SERVICES NEXT OF KIN AUTHORIZATION FOR REMOVAL

## DECEDENT INFORMATION

First Name of Decedent:

Last Name of Decedent:

## NEXT OF KIN / LEGAL REPRESENTATIVE INFORMATION

First Name:

Last Name:

Relationship to Decedent:

Mailing Address:

City, State, Zip Code:

Phone Number:

Email:

Funeral Home Name:

Funeral Home Mailing Address:

City / State / Zipcode:

Phone Number:

Funeral Home Email:

**This is to certify that I, the above listed legal next of kin, having the relationship listed above, hereby authorize the stated funeral home above to remove and care for the body of the above listed decedent from the Hennepin Healthcare Services Morgue for the purpose of funeral arrangements, embalming, shipping, cremation, burial, or other means of final disposition.**

Next of Kin / Legal Representative Signature:

Date Signed:

## PORTION BELOW TO BE COMPLETED BY THE FUNERAL HOME

I, _____ with _____ received
(print name) (name of funeral home)

this completed authorization from the above named person on _____ at _____.
(date) (time)

Signature of name of funeral home employee accepting this form _____