For Office Use Only

Validated by: _____

Date: _____

Authorization / Identification Consent Form

For assistance please contact us 24/7 at (313) 894-1334. Incomplete or inaccurate forms will be returned for correction.

Full Legal Name of Deceased: _____

(as it appears on Social Security Card)

Date of Birth: Month_____**Day**_____**Year**_____

What is your relationship to the donor?: _____ Priority order = 1. Self 2. Spouse 3. Adult child 4. Parent 5. Sibling 6. Guardian 7. Next degree of kindred 8. Donor's estate representative 9. Medical Power of Attorney (if Power of Attorney send document).

I/we the undersigned, represent and warrant to and agree with Professional Mortuary Services as follows: hereby authorize to take remains of the above mention deceased into the care of Professional Mortuary Services and arrange for the following disposition of the remains by the means of:

☐ **Cremation**

☐ **Burial**

☐ **Donation/Other** _____

I/we assume full responsibility and liability for mistaken identity or incorrect identification of the human remains that were delivered to the funeral home and i/we agree to indemnify, release and hold the funeral home and its affiliates, officers, employees, agents, sub contractors and assignees harmless from any and all claims, losses, damages, liabilities or cause of action (including Attorney fees and expenses of litigation) arising as a result, based upon, or connected with the disposition of the human remains of the deceased as indicated herein, including, without limitation, my/our failure to correctly identify the human remains that were delivered to the funeral home.

I authorize any and all medical information to be released to Professional Mortuary Services before or after death, including but not limited to a complete medical history. Make it be known that the family of the deceased must inform the funeral home if the deceased died knowingly died of HIV, hepatitis B and hepatitis C. All protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) will remain confidential and be kept in a secure location and will remain anonymous.

I have had adequate time for consideration and all my questions have been answered. I understand that signing this document does authorize **Professional Mortuary Services** to bring into their care the remains of the fore mentioned deceased. I hereby verify my understanding of all listed disclosures as indicated by my signature below:

Signature of Consenter*: _____ Date Signed: _____

***If signed by someone other than the deceased's next of Kin, the signatures of the consenter and witnesses indicate that the deceased is physically unable to sign and has directed that the form be signed at their request in accordance with Michigan law.**

Address of Person Granting Consent: _____ City: _____

State: _____ Zip: _____ Phone Number: _____ Email: _____

Must have two witness signatures of persons 18 or older. Witnesses cannot be the person consenting to release.
At least one witness signature must be a 'disinterested party' (not a relative or caregiver).

Witness Signature 1*: _____ Print Name: _____ Date: _____

Witness Signature 2*: _____ Print Name: _____ Date: _____