



Health

FAMILY NAME

MRN

GIVEN NAME

☐ MALE ☐ FEMALE

Facility:

D.O.B. ____/____/____

M.O. _____

ADDRESS _____

**AUTHORITY TO
COLLECT DECEASED**

LOCATION / WARD _____

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PART A: To be completed by the Executor or Next of Kin (See Part D for guidance)

Given Name _____ Family Name _____

Address _____

Contact Phone Number _____

I (print name) _____

give authority to (Funeral Director) _____

to collect the body of (name of deceased) _____

Relationship to Deceased _____

If nominated as a delegate of the Executor/Next of Kin, please provide details: _____

I confirm that I have full and proper authority to permit the facility to release the body of the above named deceased person to the funeral director on this form.

Signature: _____ Date: _____

PART B: To be completed by Funeral Director (Where a person collecting the body is not a funeral director or acting on behalf of the coroner, please contact the Public Health Unit to confirm whether all necessary approvals have been obtained)

Funeral Company Name _____

Address _____

Transfer Company (if applicable) _____

Contact Person _____

Phone: _____ Fax or Email: _____

Date: _____ Signature: _____

PART C: To be completed by NSW Health Staff

This section requires two NSW Health Staff (as determined by the local facility) to witness that sections A and B have been completed prior to the release of the body to the funeral director.

Staff Member 1 Name: _____ Signature: _____

Designation: _____ Date: _____

Staff Member 2 Name: _____ Signature: _____

Designation: _____ Date: _____

AUTHORITY TO COLLECT DECEASED

SMR020.210

NO WRITING



SMR020210

Holes Punched as per AS2826.1: 2012
BINDING MARGIN - NO WRITING

NH700576 111219