**Saginaw County Office of Medical Examiner**
**1600 N. Michigan Avenue, Suite 503**
**Saginaw, Michigan 48602**
**Office: (989) 790-5533 Fax: (989) 790-5466**
**Email: medicalexaminer@saginawcounty.com**
**Russell L. Bush, MD, MPH**
**Chief Medical Examiner**

# RELEASE OF MEDICAL EXAMINER INFORMATION*

I, _____, as legal next of kin, give my permission to **the Saginaw Office of Medical Examiner** to release the following documents/records:

| | | |
|---|---|---|
| **1. Autopsy Report** | **YES** □ | **No** □ |
| **2. Toxicology Report** | **YES** □ | **No** □ |

**DECEDENT IDENTITY:**

Printed Name: _____ Date of Birth: _____ Date of Death: _____

Address: _____ City: _____ Zip: _____

**FOR WHAT PURPOSE (*Check all that Apply*):**

| | | |
|---|---|---|
| **1. Insurance** | **YES** □ | **No** □ |
| **2. Legal (Attorney)** | **YES** □ | **No** □ |
| **3. Physician** | **YES** □ | **No** □ |
| **4. Self** | **YES** □ | **No** □ |

□ I realize that the ***ONLY*** records that will be released are those ***ORIGINATING*** in the Medical Examiner's Office. Those produced by other medical, law enforcement, emergency services, and other organizations that we may have copied records for our internal investigation will not be included. Those records will need to be acquired from their original source.

**Relationship: □ Spouse □ Child (over 18 y/o) □ Parent □ Grandparent □ Sibling □ POA**

**Signature: _____ Date: _____**

**Printed Name: _____ Telephone: _____**

**Address: _____ City: _____ Zip: _____**

***When requesting records, the following are required:**
**Copy of photo Identification and current contact information including full name, working phone number, and original signature on the written request.**