



**King County Medical Examiner's Office**

Harborview Medical Center  
325 Ninth Avenue, Box 359792  
Seattle, WA 98104-2499  
**206-731-3232** Fax 206-731-8555  
TTY Relay: 711  
www.kingcounty.gov/health

*Public Health/King County Medical Examiner is not obligated to honor this request unless all portions are completed and a copy of the next of kin/legal representative's driver's license is included.*

**Authorization for Release of Specimens held by the King County Medical Examiner's Office**

I, \_\_\_\_\_ am the \_\_\_\_\_  
(RELATIONSHIP TO DECEDENT)  
To: \_\_\_\_\_ ME #: \_\_\_\_\_  
(DECEDENT NAME)

**Choose ONE Payment Link Preference**

E-mail : \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

I authorize the King County Medical Examiner's Office to release the requested specimens, on my behalf, to:

\_\_\_\_\_  
(Name of Organization)  
\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)

**I understand that I am responsible for the laboratory selection and test selection. I acknowledge that I am responsible for all shipping and lab testing fees in addition to the \$50.00 non-refundable fee paid to the King County Medical Examiner's Office for processing, storage, retrieval and handling of biological specimens.**

\_\_\_\_\_  
(Print Name of Next of Kin/Legal Representative)      \_\_\_\_\_  
(Signature of Next of Kin/Legal Representative)  
\_\_\_\_\_  
(Date)      \_\_\_\_\_  
(Contact Phone Number)